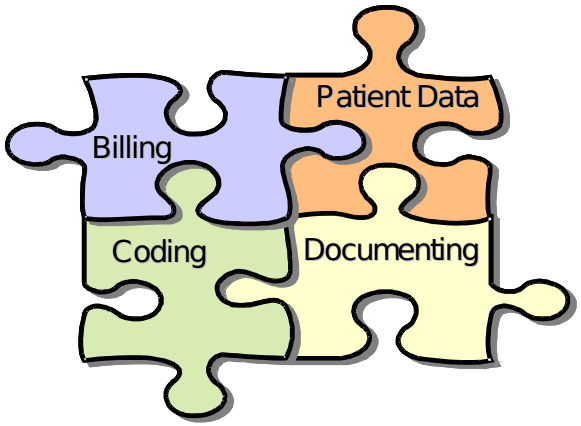
CORE COMPETENCIES

2005 UBU/UBO Conference
UBU Advanced (Track 2)

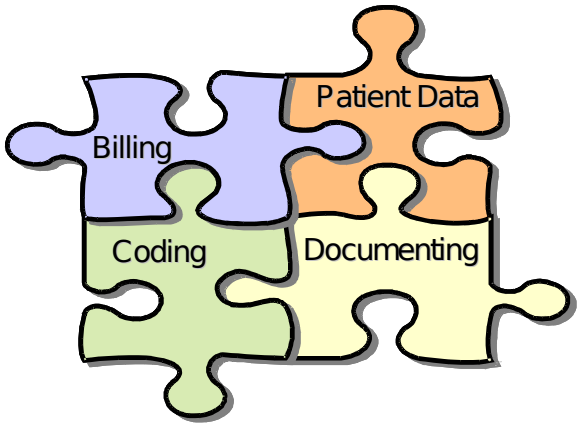


Thursday - May 19

Contents:

1. Improving Day-to-day Operations in the H.I.M. Using Com puters (Kindsvater, Sandi)
2. Playing Records “Beat the Clock” (Pegum, Kathy)
3. Emergency Medicine Coding (Millican, Lesvia; Plager , Emily)
4. CCE- Be Proactive Fix Your Data! (Millican, Lesvia)
5. RVU For Everyone (James, Ron)
6. Conference Wrap-up (Yoder, Lt Col Jeanne)

CORE COMPETENCIES

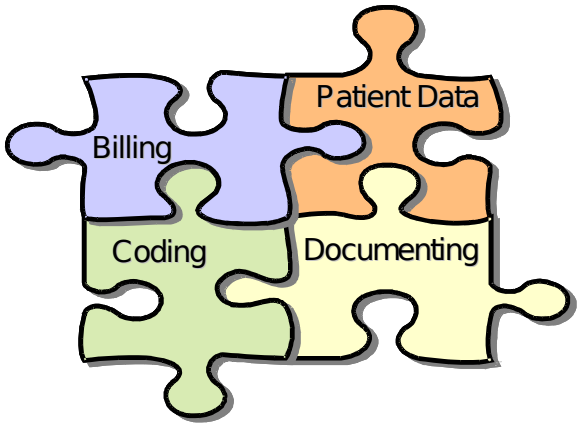


IMPROVING DAY-TO-DAY OPERATIONS IN THE H.I.M. USING COMPUTERS

Sandi Kindsvater, R.H.I.A
Europe Regional Medical Command
UBU / UBO Conference
19 May 2005
Track 2, UBU

CORE COMPETENCIES

OBJECTIVES

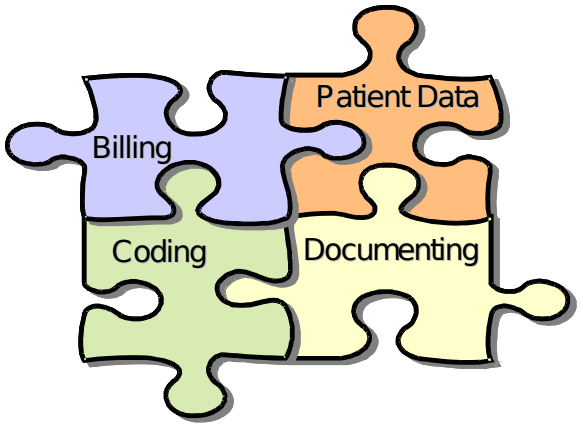


- **Discuss Two Areas of Process Improvement in a Europe Military Treatment Facility (MTF)**

1. **Occurrence Reporting**
2. **Coding & Smart Pad in CHCS I and II**

CORE COMPETENCIES

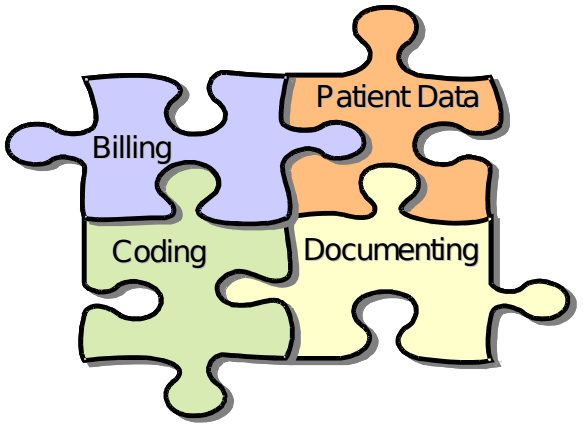
1. Occurrence Reporting



- The Manual Process
- How the Process was Changed
- What was the Impact of the New Process
- Lessons Learned

CORE COMPETENCIES

MISSION- H.I.M.



- **Report Incident/Occurrences in the MTF to the Patient Safety Department**

Who was Involved:

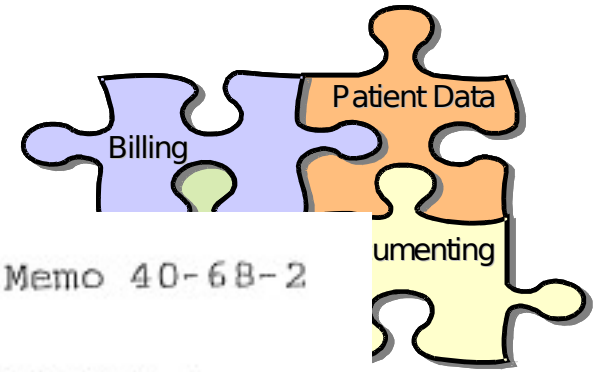
HIM Coders and Clerks

Information Management

Patient Safety Manager

CORE COMPETENCIES

Occurrence Reporting



USAMH Memo 40-68-2

APPENDIX A Date received in PS: _____

UNUSUAL OCCURRENCE REPORT

For use of this form see MEDCOM Cir XX-XX

DATE of EVENT:

	2. Time of Event:	3. Census:	4. Nursing Care Hours:	5. Patient Acuity Level: (I - V
ITE: USAMH				

Patient ☐ Staff ☐ Visitor Name (print clearly) _____

Visitor Address: _____ Daytime Phone: _____

Diagnosis: _____ ☐ Male ☐ Female Age _____

Allergies: _____

SECTION I - LOCATION/DESCRIPTION of EVENT

Inpatient ☐ Ward/Unit: _____ ☐ ER: (specify location) _____

Outpatient ☐ Clinic: _____ ☐ Other: _____

scribe the event: (Give specific details):

SECTION II - ACTUAL STAFF on DUTY at TIME of EVENT

: _____ LPN/91C: _____ NA/91B/91W: _____ Pharmacist: _____ Physician: _____ Tech: _____

SECTION III - TYPE of EVENT (Select all that apply)

Actual ☐ Near Miss/Close Call (Select one)

AMA/Left Without Being Seen

Adverse Drug Related Event

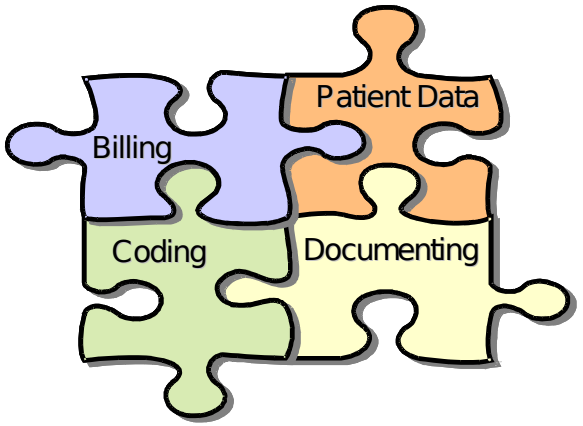
Assault

- ☐ Patient to Patient
- ☐ Patient to Staff
- ☐ Patient to Visitor
- ☐ Staff to Staff
- ☐ Visitor to Staff
- ☐ Visitor to Visitor

- ☐ Exposure to Blood/Body Fluids
- ☐ Fall (go to Section XVIII)
- ☐ Infant Abduction ☐ Discharge to Wrong Family
- ☐ Informed Consent
- ☐ Laboratory Related (go to Section IX)
- ☐ Medication Related (go to Section XV)
- ☐ Needlestick/Sharps
- ☐ Obstetrics Related (go to Section X)

CORE COMPETENCIES

Occurrence Reporting



- **Incidence/Occurrence Reporting**
- **Manual Process:**

  Chart is Reviewed /DOD Form

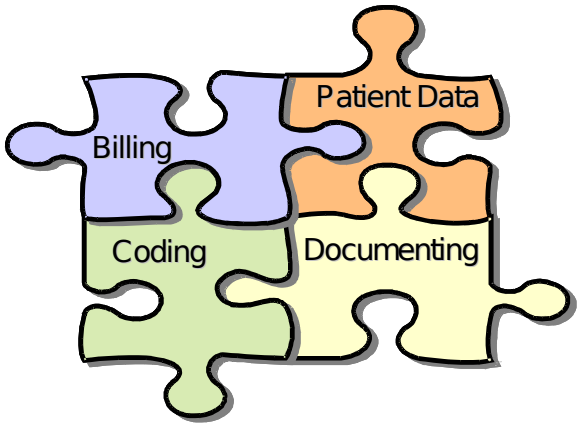
  Takes 15 Min/One Person to Complete

  Form is sent thru Departmental Mail

  Data Reporting is Limited by Form

CORE COMPETENCIES

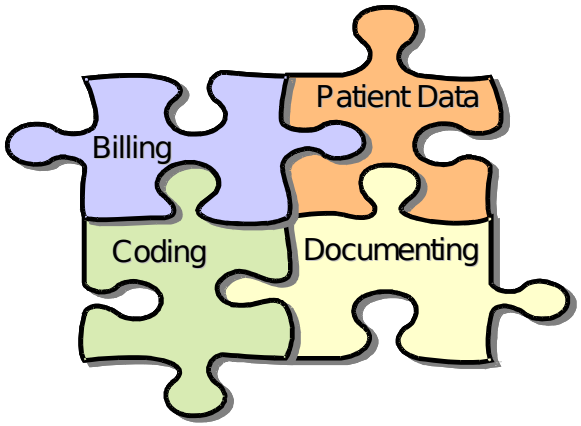
Occurrence Reporting



- Reasons for Converting to Electronic
- Use Spreadsheet Format
- Secure Shared Folder for Input and Reporting
- Enter Data Only Once
- Many Users Can Access Data
- Data Reported in Timely Manner

CORE COMPETENCIES

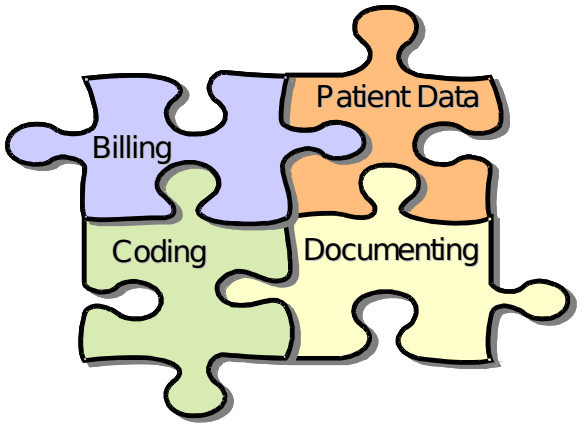
Occurrence Reporting



REVIEW D	OCCUR D	DEPT	PT NAME	SSN	FORM	OCC/DIS	HCP	STAFF	PT SAFETY REV
5-May-05	1-Apr-05	ORTHO	SAMPLE	1000	SF 522	NO TIME ON CONSENT	CPT JONES	SKK	15-May-05
10-May-05	1-May-05	OB/GYN	SIMPLE	2000	SF 522	NO WITNESS SIGN	MAJ HALL	JR	30-May-05

CORE COMPETENCIES

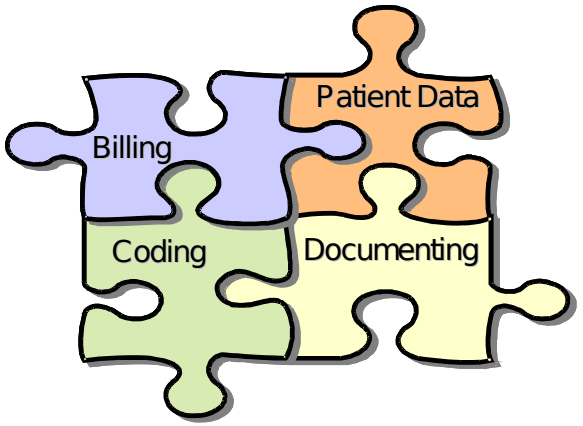
Occurrence Reporting



- **Impact of the New Process:**
- **Less than 5 minutes complete**
- **Many Users Can Enter Data**
- **Can be Used for other Systems (ex. Infection Control)**

CORE COMPETENCIES

2. Coding & Smart Pad in CHCS I & II

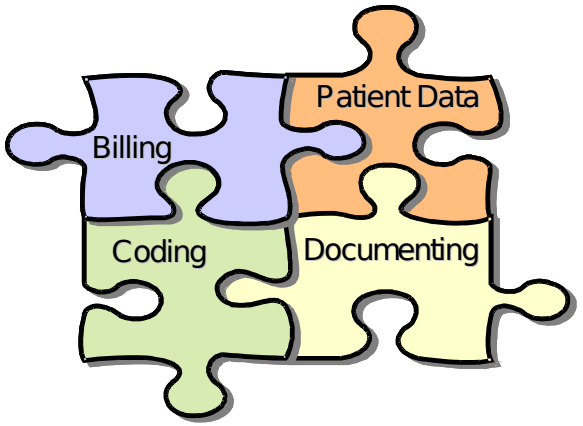


- MISSION- H.I.M.

- **Coding**
- **Medical Conditions - ICD-9-CM**
- **Procedures - CPT & E&M**

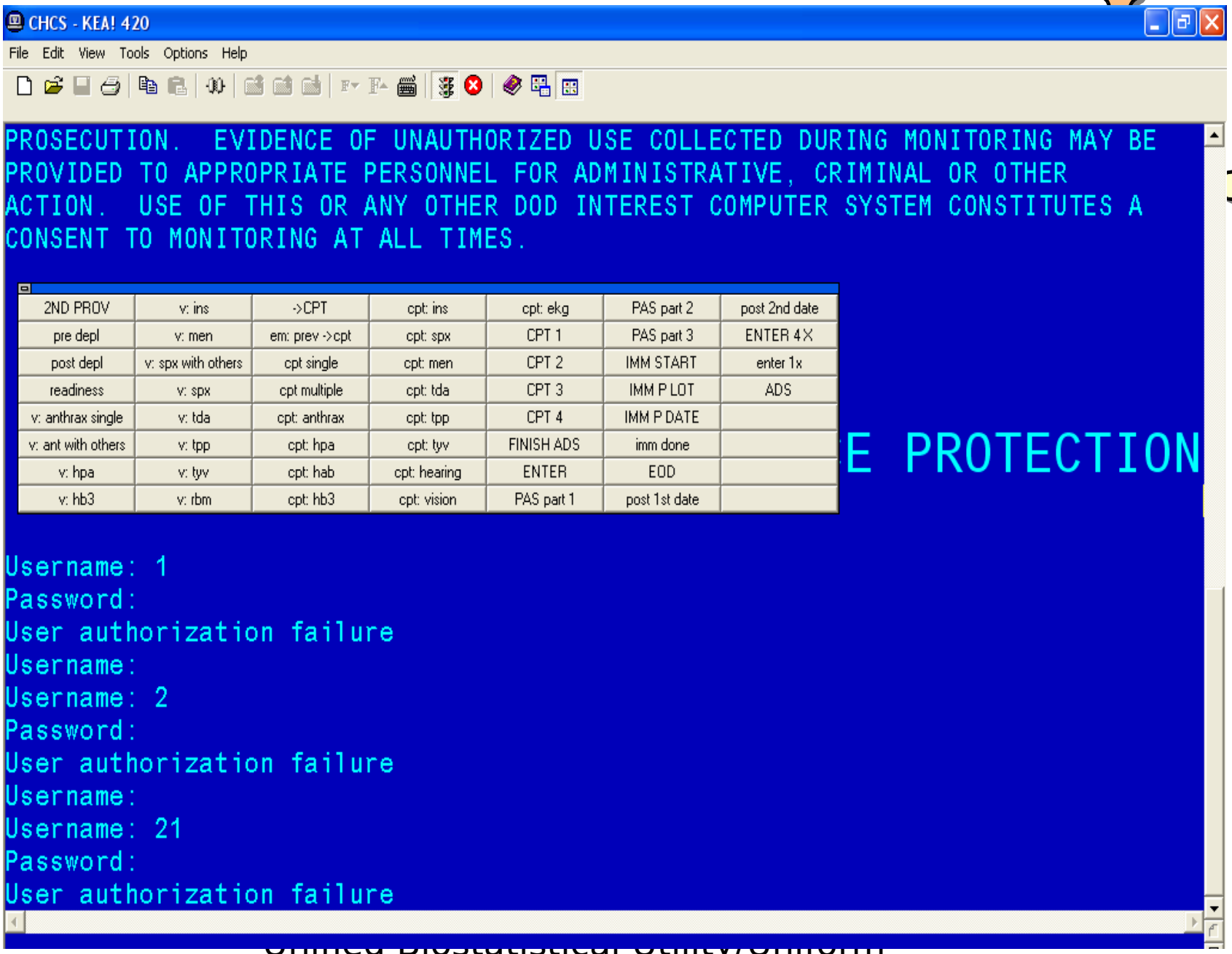
CORE COMPETENCIES

CHCS I Smart Pad



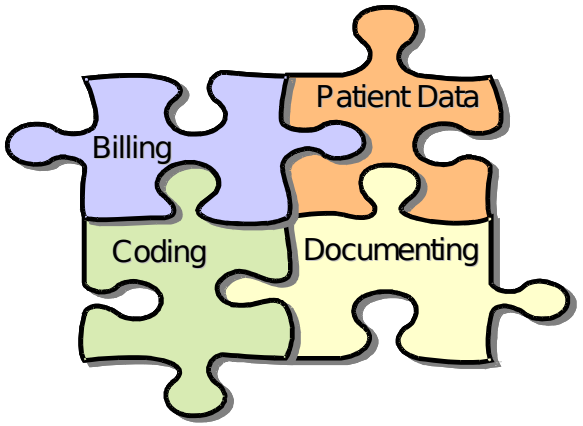
- **Well Baby Visit (4 month old)**
- **Log on to CHCS I**
- **Codes for this visit: V20.2, V06.8, V03.81, V0382**
- **E&M 99391**
- **CPT 90465, 90466, 90723, 90648, 90669**
- **Takes 29 Key Strokes**

CORE COMPETENCIES


CHCS - KEA! 420
File Edit View Tools Options Help
PROSECUTION. EVIDENCE OF UNAUTHORIZED USE COLLECTED DURING MONITORING MAY BE PROVIDED TO APPROPRIATE PERSONNEL FOR ADMINISTRATIVE, CRIMINAL OR OTHER ACTION. USE OF THIS OR ANY OTHER DOD INTEREST COMPUTER SYSTEM CONSTITUTES A CONSENT TO MONITORING AT ALL TIMES.
2ND PROV | v: ins | ->CPT | cpt: ins | cpt: ekg | PAS part 2 | post 2nd date
pre depl | v: men | em: prev ->cpt | cpt: spx | CPT 1 | PAS part 3 | ENTER 4X
post depl | v: spx with others | cpt single | cpt: men | CPT 2 | IMM START | enter 1x
readiness | v: spx | cpt multiple | cpt: tda | CPT 3 | IMM P LOT | ADS
v: anthrax single | v: tda | cpt: anthrax | cpt: tpp | CPT 4 | IMM P DATE |
v: ant with others | v: tpp | cpt: hpa | cpt: tyv | FINISH ADS | imm done |
v: hpa | v: tyv | cpt: hab | cpt: hearing | ENTER | EOD |
v: hb3 | v: rbm | cpt: hb3 | cpt: vision | PAS part 1 | post 1st date |
E PROTECTION
Username: 1
Password:
User authorization failure
Username:
Username: 2
Password:
User authorization failure
Username:
Username: 21
Password:
User authorization failure

CORE COMPETENCIES

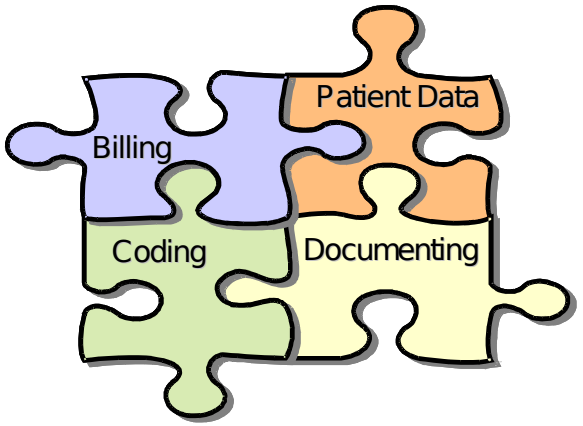
CHCS I Smart Pad



- **Comparison of sample visit Log-On to Log-Out:**
- **Before: Coded 80 visits per day**
  29 key strokes per visit
- **After: Coded 150 visits per day**
  3-5 key strokes per visit

CORE COMPETENCIES

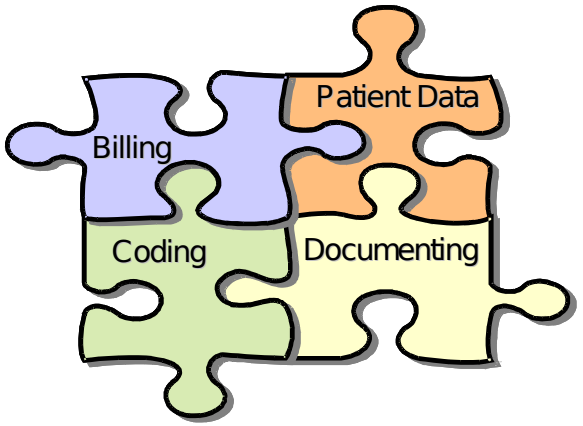
CHCS I Smart Pad



- **Lessons Learned**
- **Various ways to Standardize your Smart Pad**
- **Save your Smart Pad Templates and Cut and Paste into New CHCS II**

CORE COMPETENCIES

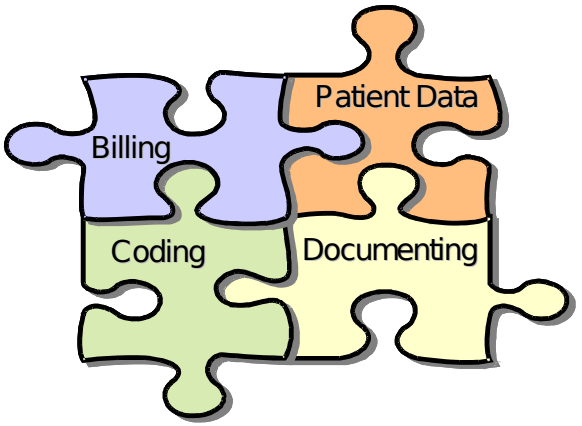
MAKING CHANGE HAPPEN

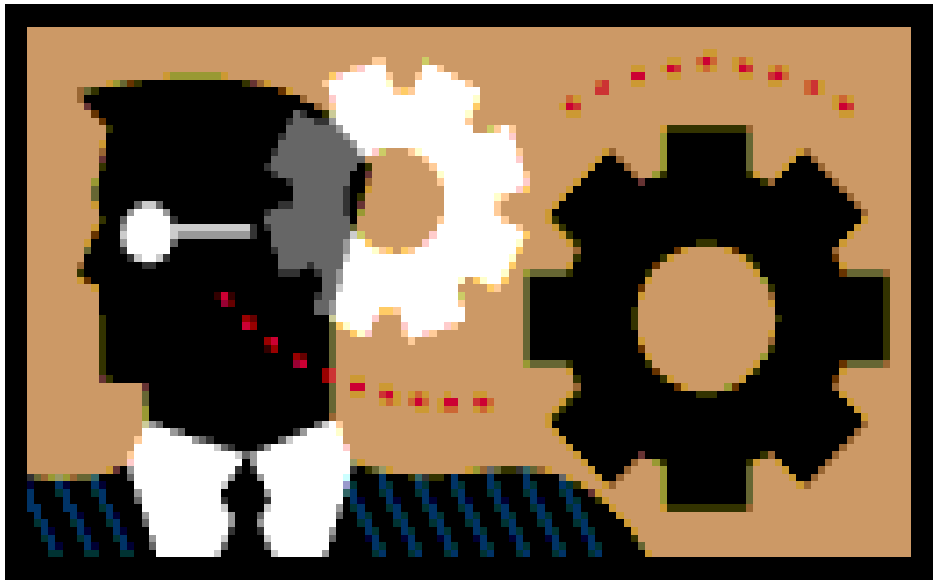


- **Forget the Status Quo:**
  "We've always done it this Way"
  Find a Leader who will champion the Process (ex. a Coder at our MTF)
- **Plan for change**
- **Test your Ideas Rapidly using Pilot Group**
- **Take what you've learned and expand**
- **Don't expect the Process to be smooth/easy**
- **Innovation requires trial and error**

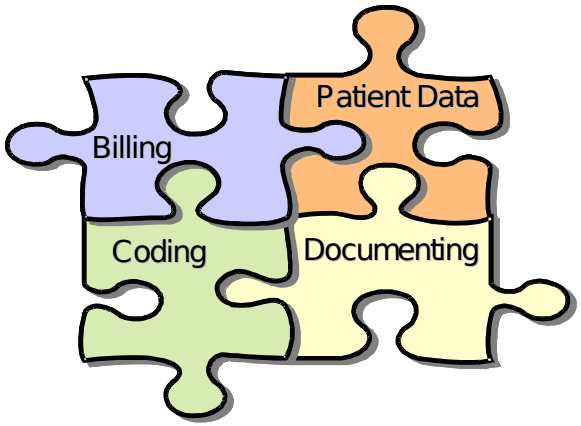
CORE COMPETENCIES

QUESTIONS





CORE COMPETENCIES

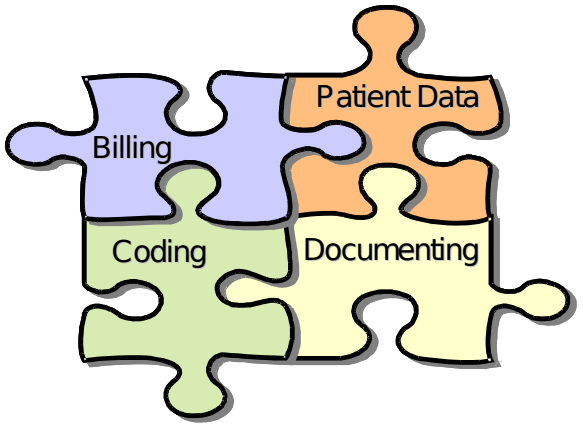


Playing Records “Beat the Clock”

Kathy Pegum, RHIT
Madigan Army Medical Center
19 May 2005
Track 2 – UBU Advanced

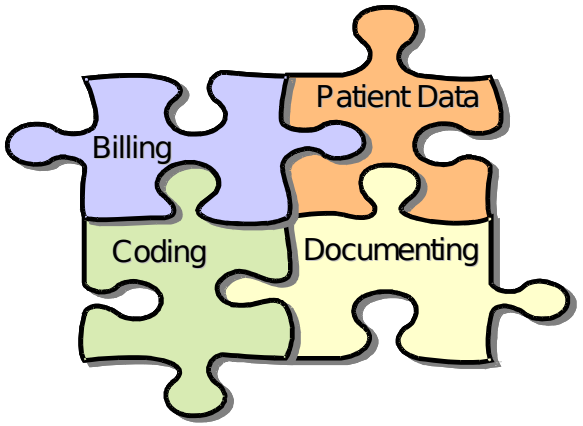
CORE COMPETENCIES

Objectives



- Know and understand your customers
- Own your records completion process
- Learn to run an effective chart room
- Hiding your gray hairs!

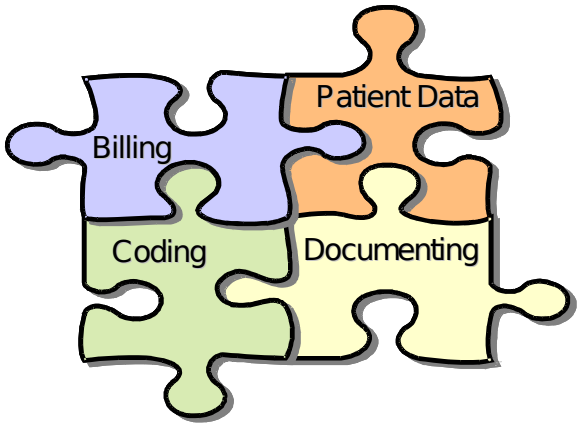
Know Your Customers



- Meet and greet them
- Listen to their “sob” story
- Give them your “sob” story (get them on your side)
- Cater to your physicians
- Use employee incentives
- Do what you say you will do

CORE COMPETENCIES

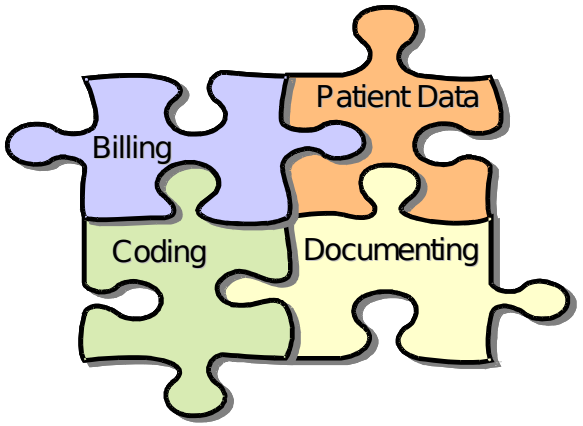
Own Your Process



- Set a time line to beat the clock
- Go to the “front”
- Use a team concept
- Maximize CHCS usage
- See the goal

CORE COMPETENCIES

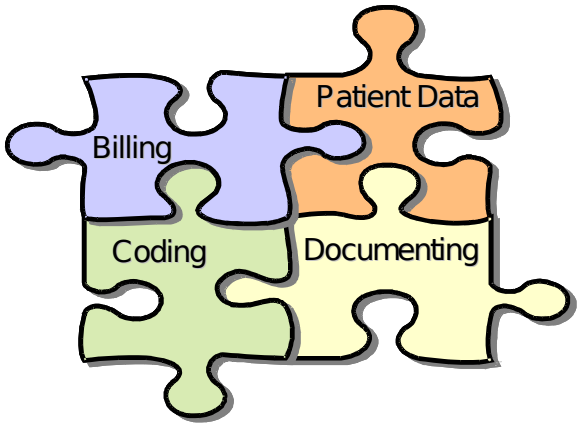
Chart Room Frenzy



- Use a “people” person
- Keep a schedule
- Set up delivery services
- Use positive incentives
- Inventory and purge

CORE COMPETENCIES

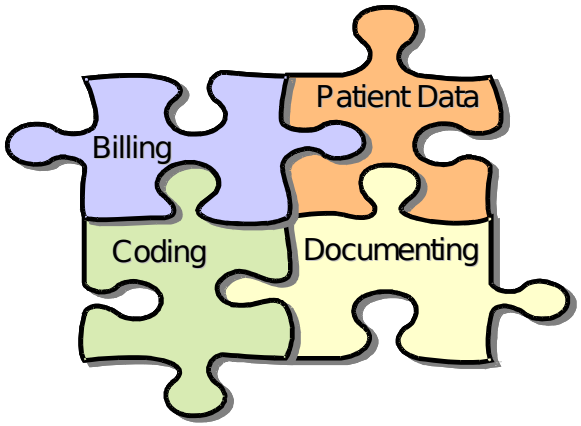
To Summarize……



- Objectives Covered:
  - Know your customers
  - Own your process to beat the clock
  - Run your chart room
- If you've worked on all of the above, then you should have fewer gray hairs to hide!
- Thank you!

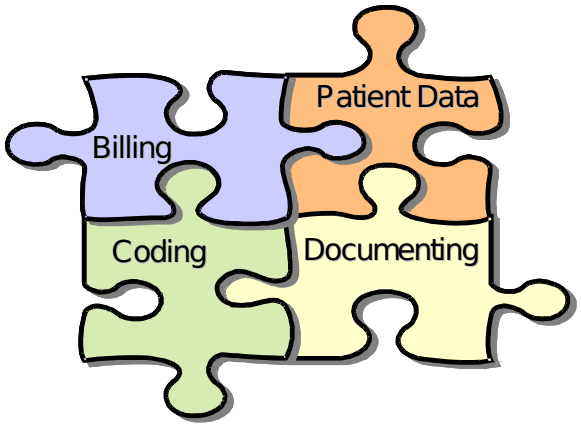
CORE COMPETENCIES

Questions



- Point of Contact:
  - Kathy Pegum, RHIT
    - Madigan Army Medical Center
    - (253)968-1815 or DSN 782-1815
    - kathy.pegum@us.army.mil

CORE COMPETENCIES

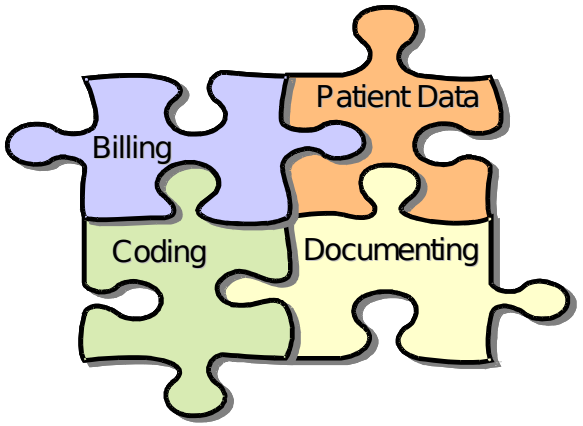


Emergency Medicine Coding

Lesvia O. Millican, CPC, PMCC
Emily Plager, CPC
May 19th, 2005
Track 2 UBU

CORE COMPETENCIES

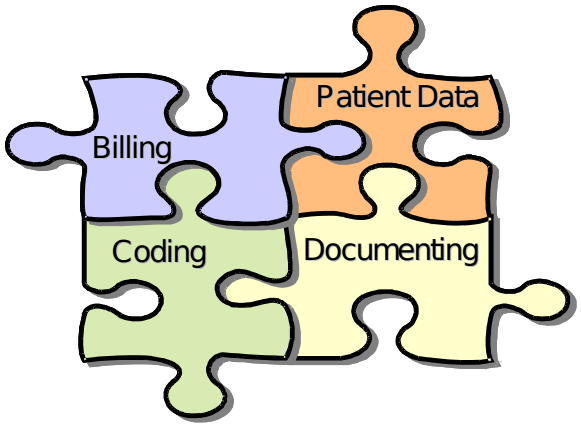
Objectives



- MTF Emergency Room
- E&M Level Criteria
- Documentation
- Procedures
- Coding
- Questions

CORE COMPETENCIES

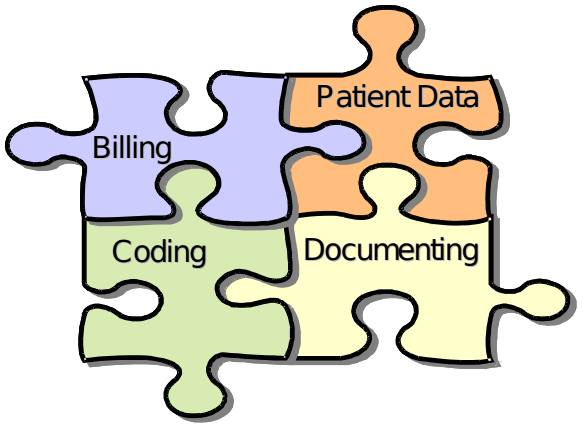
MTF Service Provided



- Emergency room services
- Consults
- Procedures
- Surgical procedures
- Ambulance

CORE COMPETENCIES

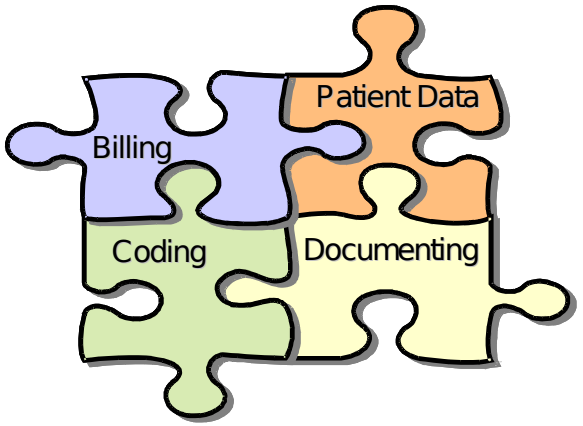
Military Facility Emergency Room



- Emergency Department
  - To qualify must be open 24 hour
    - Critical Care
    - Observation
    - Admissions
    - Discharges
- Urgent Care
  - Default to regular office E&M's

CORE COMPETENCIES

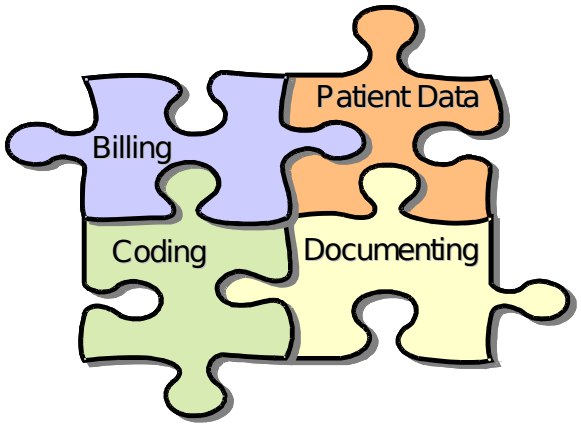
Documentation



- Time
  - Need not be continuous
  - Count time that relates to the patient
- Patient severity
  - Patient unable to communicate
  - Unconscious
- Procedures
- Critical care
- GME/Resident Care

CORE COMPETENCIES

Documentation

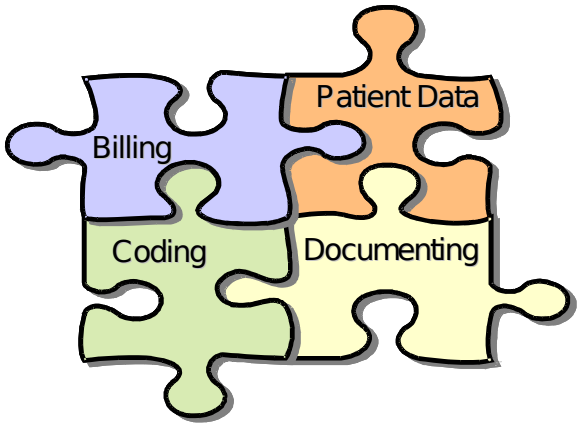


- Note!!!!

  The severity of the patient's problem, while taken into consideration when evaluating and treating the patient, does not automatically determine the level of E/M service unless the medical record documentation reflects the severity of the patient's illness, injury, or condition.
- Details must be included in:
  - History
  - Exam
  - Medical decision

CORE COMPETENCIES

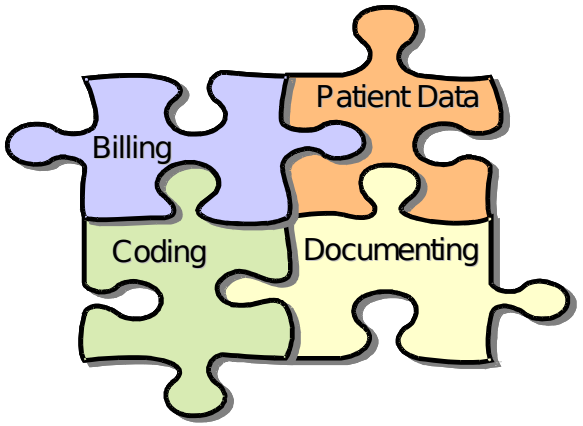
Documentation



- No Distinction between New or Established Patients
- Key Components-Crucial for selection of level
  - History
  - Exam
  - Medical Decision Making
  - Modifier –25 added for significant procedures except Lab and Radiology

CORE COMPETENCIES

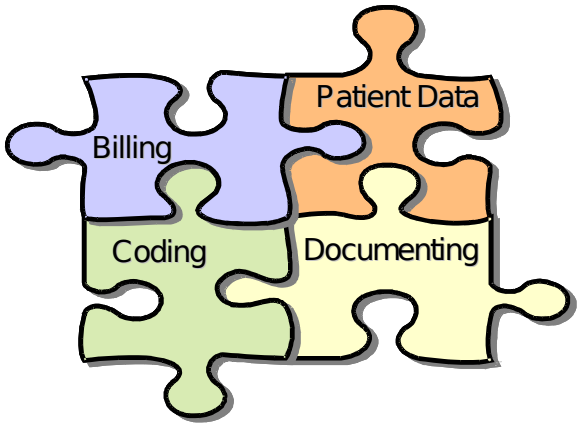
Documentation



- 5 Levels of E/M Codes
  - 99281
    - History – Problem Focused
    - Exam – Problem Focused
    - Medical Decision Making – Straight-forward
      - Problem Severity - Minor or self-limited
  - 99282
    - History – Expanded Problem Focused
    - Exam – Expanded Problem Focused
    - Medical Decision Making – Low
      - Problem Severity - Low to moderate

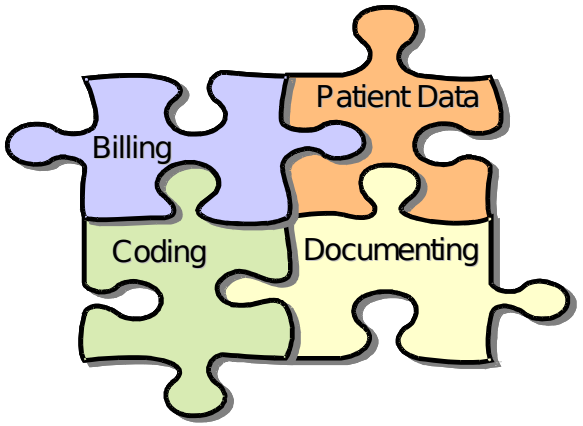
CORE COMPETENCIES

Documentation



- 99283
  - History – Expanded Problem Focused
  - Exam – Expanded Problem Focused
  - Medical Decision Making – Moderate
    - Problem Severity - Moderate
- 99284
  - History – Detailed
  - Exam – Detailed
  - Medical Decision Making – Moderate
    - Problem Severity - Requires urgent evaluation

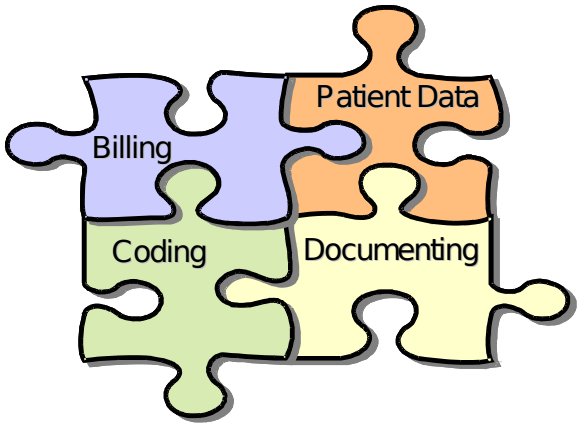
Documentation



- 99285
  - History – Comprehensive
  - Exam – Comprehensive
  - Medical Decision Making – High
    - Poses immediate/significant threat to life or physiologic function

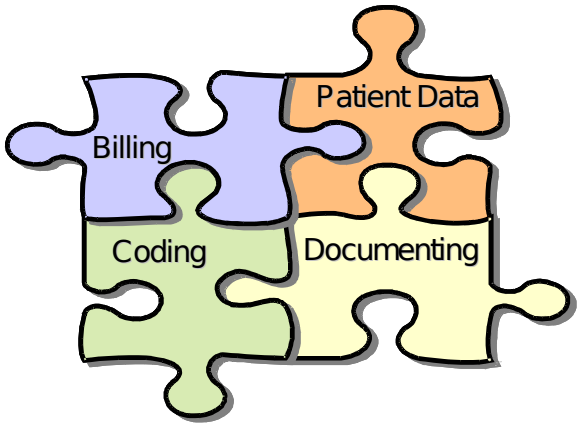
CORE COMPETENCIES

Emergency Department E&M



- Definition of ED visit:
- Facility Models
- Assignment of levels based on model
- Levels assigned as performed by hospital staff
- Facility benefits

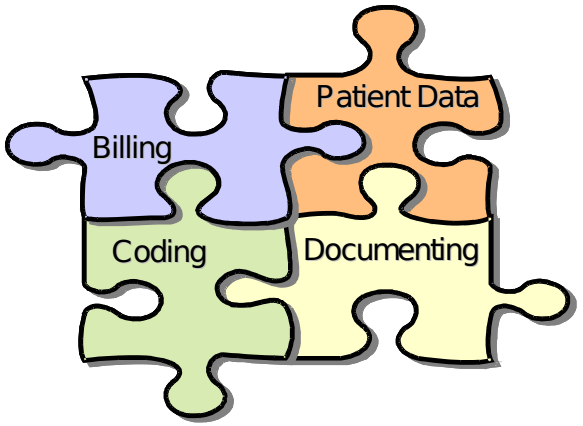
Emergency Department Facility Coding



- Level I Intervention
  - At least one item below qualifies:
    - Initial Assessment
    - No medications or treatments; Suture removal
    - Wound recheck; Note for Work or School
    - Discussion of Discharge Instructions (Straightforward)

CORE COMPETENCIES

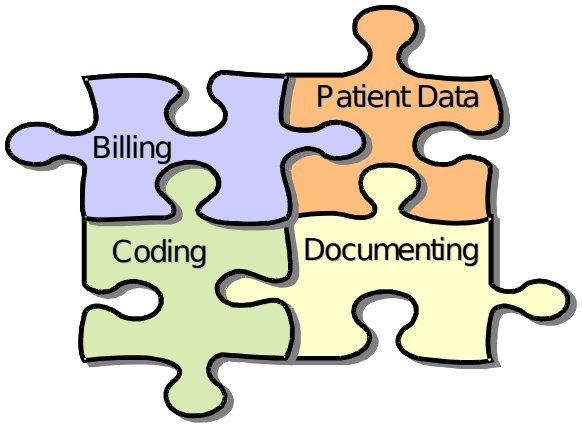
Emergency Department Facility Coding



- Level II Interventions
  - At least one item below qualifies:
    - Over-the-counter medications
    - Administration; Tetanus Shot
    - Tests by ED staff (Urine dip, stool hemoccult, Accucheck or Dextrostix)
    - Visual Acuity (Snellen)
    - Discussion of Discharge Instructions (Simple)

CORE COMPETENCIES

Emergency Department Model

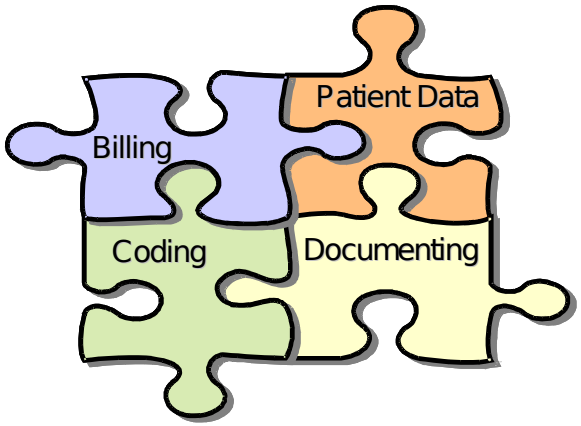


- Contributory factors for raising levels
  - At least one item below qualifies:
    - Airway insertion
    - Altered mental status
    - Schedule ancillary services
    - Multiple interventions
    - Patient acuity
    - Patient discharge other than home
    - Reporting or contacting local services

From Low level to Mid-Level OR from Mid-Level to High level

CORE COMPETENCIES

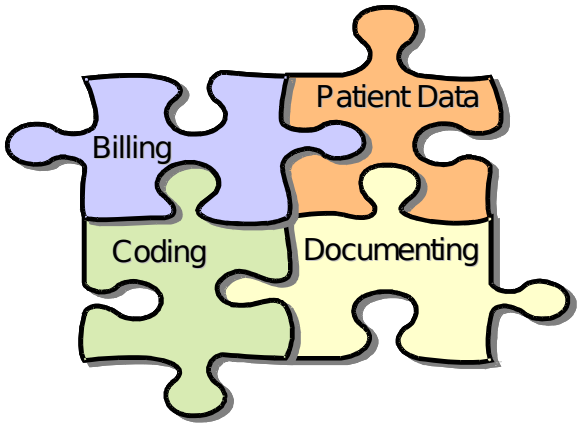
Emergency Department Model



- Level III Intervention
  - At least one item below qualifies:
    - Heparin/Saline Lock, Crystalloid IV Therapy
    - Prep for Lab tests described in CPT (80048087999 codes)
    - Prep for plain x-rays of only 1 area
    - Rx medications (PO Med), Administration
    - Fluorescein Stain
    - Foley caths
    - In & Out catheterization
    - Coordination of DOA
    - Receipt of EMB/Ambulance patient
    - Mental Health-anxious, simple treatment
    - Discussion of Discharge Instructions (Moderate Complexity)

CORE COMPETENCIES

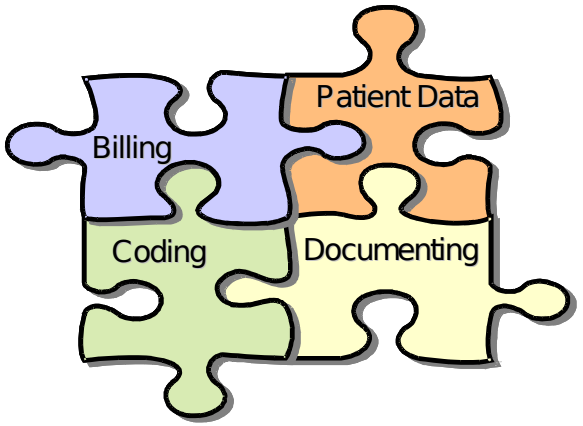
Emergency Department Facility Coding



- Level IV Interventions
  - At least one item below qualifies:
    - **Prep for plain x-ray**
    - **Prep for special imaging studies – MRI, C-T Scans, etc.**
    - **Cardiac Monitoring(monitor for complication); Multiple reassessments**
    - **Parenteral Medications, Administration & monitoring (incl. Insulin)(IV/IM)**
    - **Pelvic exam; Sexual Assault exam w/out specimen collection**
    - **Assist PMD with diagnostic/therapeutic procedure/intervention**
    - **Discussion of Discharge Instructions (Complex)**
    - **Psychotic pt., not suicidal**

CORE COMPETENCIES

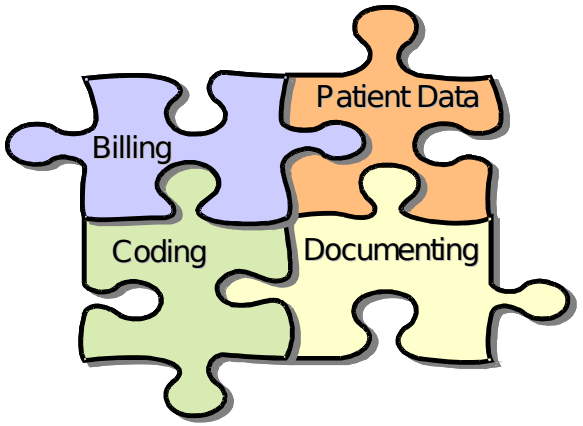
Emergency Department Facility Coding



- Level V Interventions
  - At least one item below qualifies:
    - Monitor/Stabilize patient during in-hospital transport and testing:
      - MRI, C-T, V-Q scan, Ultrasound, Vascular Exam
    - Parenteral scheduled medications, administration and monitoring
    - Vaso-active Meds (NTG, Nipride, Dopamine, Dobutamine), Monitoring
    - Multiple Nebulizer Treatments (3+)
    - Conscious sedation; CVP line insertion; Thoracentecis; Lumbar Puncture
    - Sexual Assault Exam w/specimen collection
    - Coordination of admission/transfer or change in living situation or site

CORE COMPETENCIES

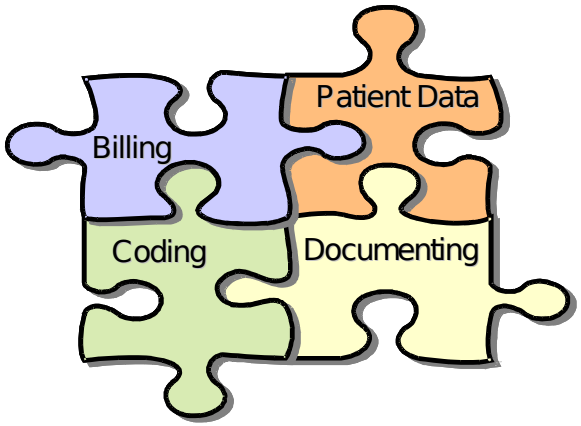
Emergency Department Facility Coding



- Level V Interventions (Cont):
  - At least one item below qualifies:
    - Fracture/dislocation reduction w/interventions
    - Mental Health problem-psychotic, agitated or combative-suicidal/homicidal
    - Physical/Chemical restraints; Suicide Watch; Seclusion
    - Gastric lavage w/heated fluids; Cooling/Heating Blanket
    - Discussion of Discharge Instructions (Complex)

CORE COMPETENCIES

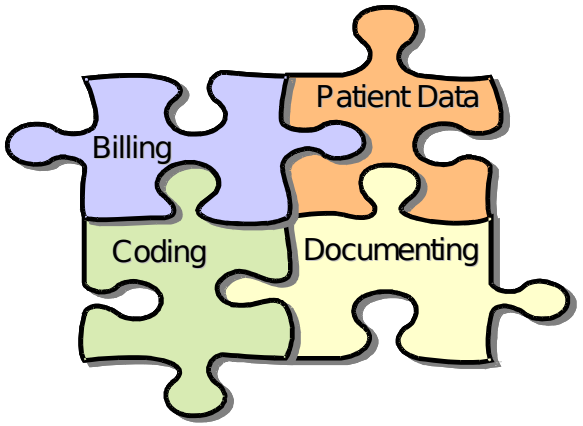
Documentation



- **Definitions for discharge instructions:**
  - **Straightforward:** condition with no meds or home treatment required, signs and symptoms o found infection explained, return to ed if problems develop.
  - **Simple:** OTC medications or treatment, simple dressing changes: patient demonstrates understanding quickly and easily.
  - **Moderate:** Head injury instructions, crutch training, bending, lifting, weight-bearing limitations prescription medication with review of side effects and potential advise reactions: patient may have questions, but otherwise demonstrates adequate understanding of instructions either verbally or by demonstration.
  - **Complex:** Multiple prescription medications and/or home therapies with review of side effects and potential adverse reactions; diabetic, seizure or asthma teaching in compromised or non-compliant patients; patient/care giver may demonstrate difficulty understanding instructions and may require additional directions to support compliance with prescribed treatment.

CORE COMPETENCIES

Critical Care Guidelines



Critical Care follows CPT Guidelines

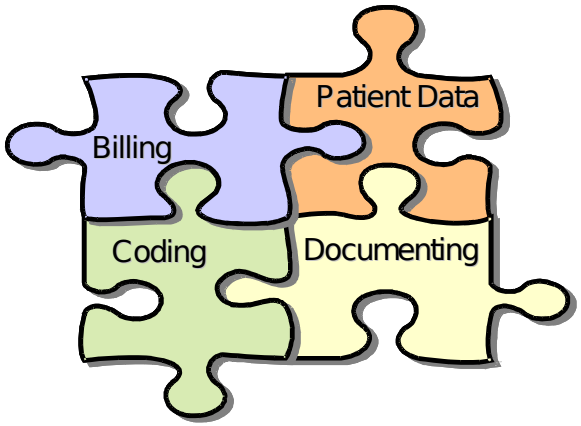
- Exception: Time not a requirement for facility use

Care Involves Decision-Making of High Complexity to Assess, Manipulate, and Support Impairments.

Such that there is a high probability of imminent or life threatening deterioration of patient's condition

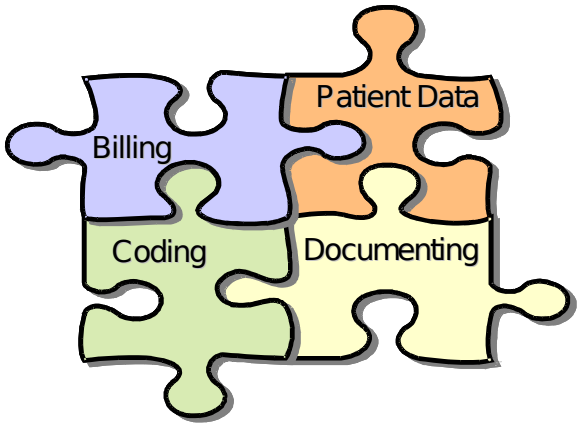
CORE COMPETENCIES

Critical Care Guidelines



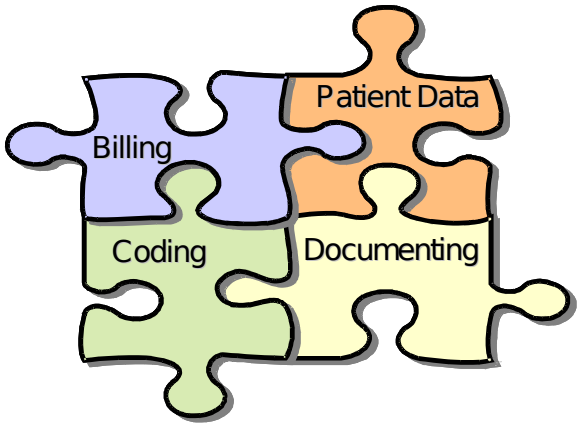
- Critical Care -99291
  - Possible Interventions
    - Multiple parenteral medications requiring constant monitoring
    - Provision of any of the following:
      - Endotracheal Intubation
      - Major Trauma Care/Multiple Surgical
      - Consultants
      - Pericardiocentesis
      - Chest Tube Insertion
      - Cricothyrotomy
      - Arterial Line Placement
      - CPR

Critical Care Guidelines



- Critical Care -99291
  - Possible Interventions
    - Defibrillation/Cardioversion
    - Administration of ACLS Drugs in CPR
    - Delivery of Baby
    - Control of Major Hemorrhage
    - Administration of Blood Transfusions/Blood Products
    - Major Burn Care
- NOTE: No Discharge Instructions as an intervention

Critical Care Guidelines

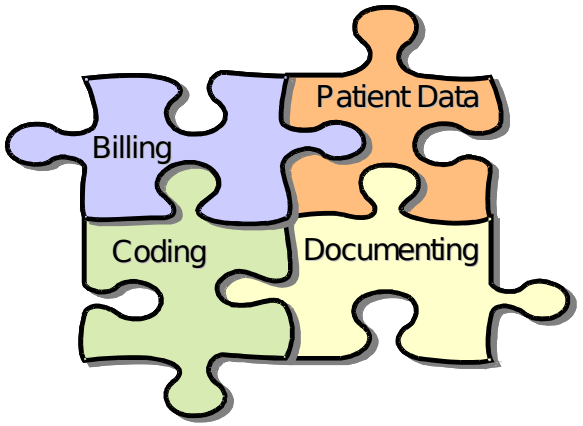


- Critical Care 99291
  - Examples which support Interventions
    - Multiple Trauma
    - Head Injury w/ loss of consciousness
    - Acute Myocardial Infarction
    - Major Pulmonary Embolus
    - Acute Failure (renal-hepatic)
    - Aneurysms

    Note: Time for 99291 is the first 30 to 74 minutes.

CORE COMPETENCIES

Critical Care Guidelines



- Critical Care – (99292)
  - Same interventions and supporting conditions in additional 30 minute intervals
  - Additional 30 increments (beyond the 1st 74 minutes)

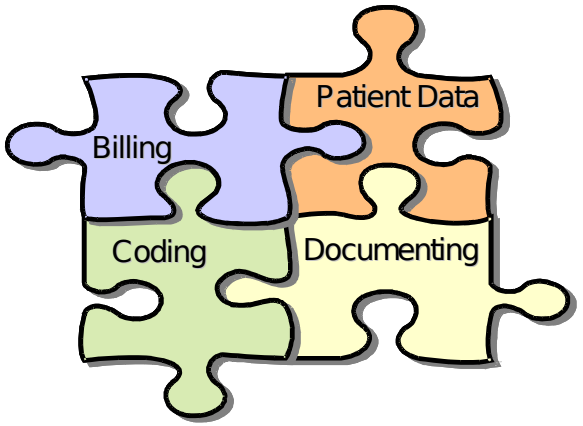
Note: Record TOTAL critical care time.

30 to 74 minutes = 99291

74 + 15 minutes = 99292

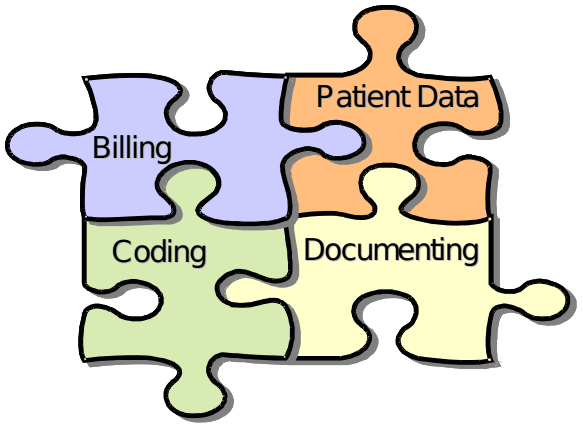
CORE COMPETENCIES

Procedures Coding



- Procedures you can not code:
  - Labs performed in the facility lab
  - Radiology exams performed in the facility lab
  - EKG's performed in the facility lab
  - Consults by other Clinic providers
  - Read and Interpretations of services performed outside the confines of the ED

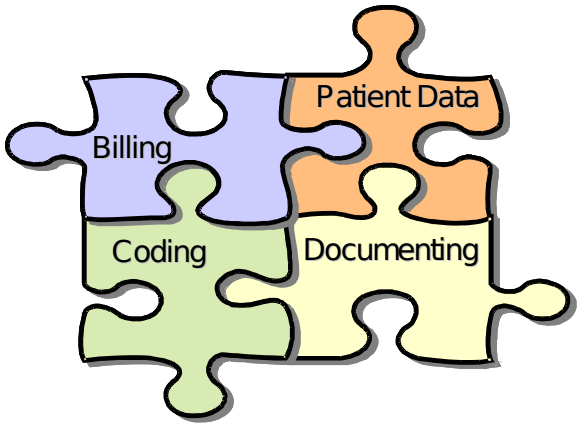
Procedures Coding



- Procedures you can code
  - EKG's if done with clinic equipment
  - Sonograms if provided with clinic equipment
  - Surgical procedures
  - Immunizations
  - Meds dispensed from clinic supply

CORE COMPETENCIES

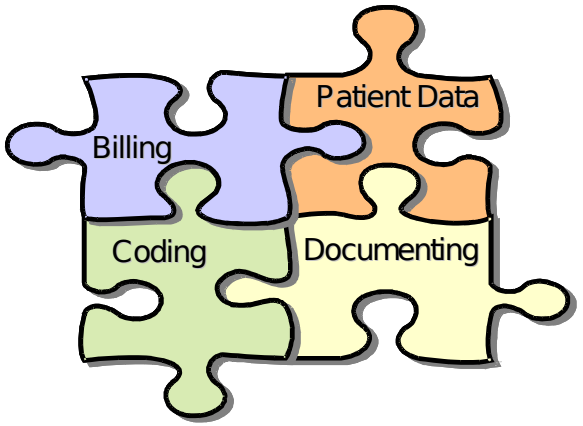
Procedures Coding



- Infusions-Therapeutic or Diagnostic
  - 90780
  - 90781 each additional hour
- Injections
  - 90783 (intra-arterial)
  - 90784 (intravenous)
  - 90788 (intramuscular injection of antibiotic

CORE COMPETENCIES

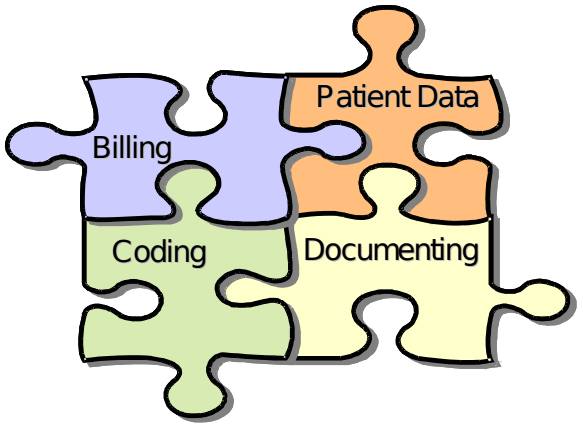
Diagnosis Coding



- Common Diagnosis
  - 009.0 Infectious colitis, enteritis, and gastroenteritis
  - 036.0 Meningococcal meningitis
  - 410.00 Acute myocardial infarction of anterolateral wall
  - 540.0 Acute appendicitis with generalized peritonitis
  - 592.0 Calculus of kidney
  - 427.41 Ventricular fibrillation
  - 430 Subarachnoid hemorrhage
  - 445.02 Atheroembolism of lower extremity
  - 491.21 Obstructive chronic bronchitis, with (acute) exacerbation
  - 800.0 Closed fracture of vault of skull without mention of intracranial injury
  - Lots of E Codes!

CORE COMPETENCIES

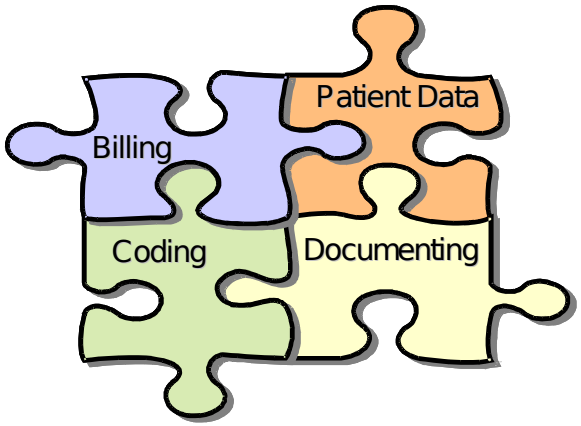
Modifiers Coding



- Modifiers available in DoD for use with E&M 99201-99499
  - -21 Prolonged E&M service
  - -24 Unrelated E&M
  - -25 Significant, separate identifiable E&M
  - -57 Decision for Surgery
  - Currently not all CPT/HCPCS modifiers available for use in DoD

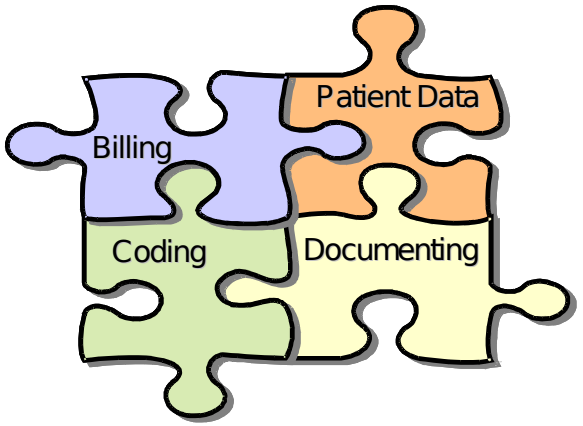
CORE COMPETENCIES

Summary



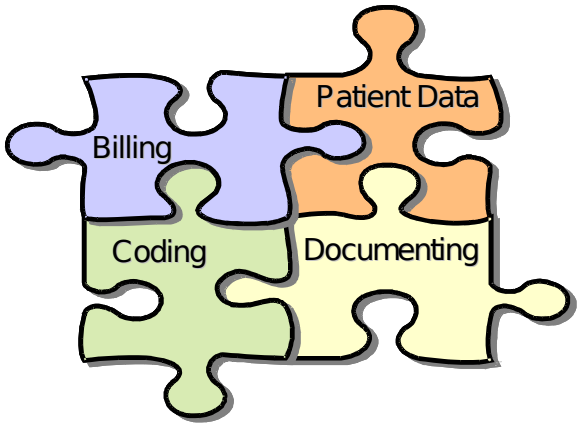
- Defined MTF ED Services
- Documentation
- Facility level criteria
- Coding

Resources



- 2005 Emergency Medicine Coding Companion
- DoD Coding Guidelines
- DoD Functional Business Rules
- American College of Emergency Physicians
- Several Really Smart Coders!!!!

References



Army http://www.pasba.amedd.army.mil

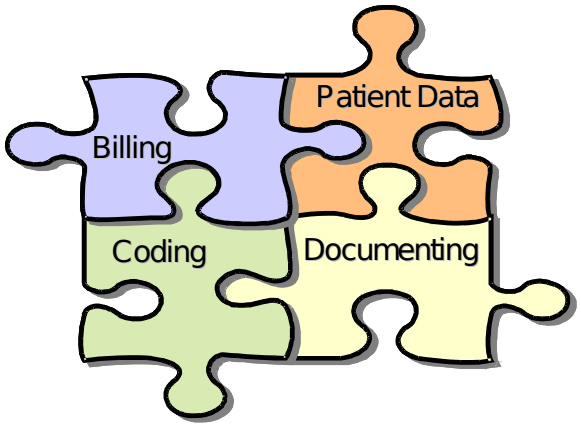
Air Force https://phsohelpdesk.brooks.af.mil

1-800-298-0230

Navy

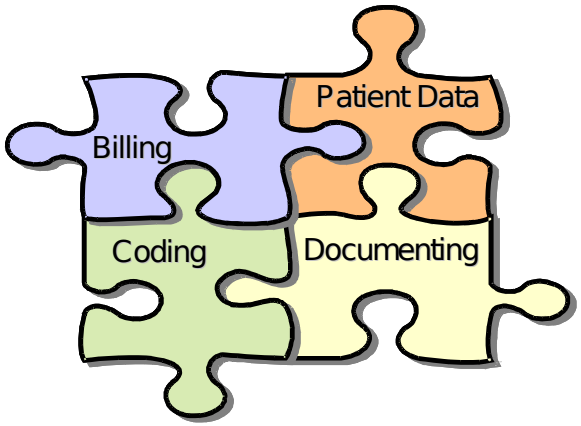
https://imcenter.med.navy.mil/045department/

CORE COMPETENCIES



Questions?

CORE COMPETENCIES



CCE- Be Proactive
Fix Your Data!

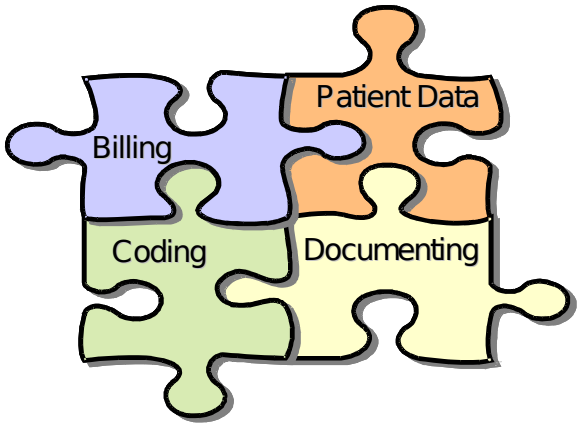
Lesvia O Millican, CPC, PMCC

May 19th 2005

Track 2 UBU

CORE COMPETENCIES

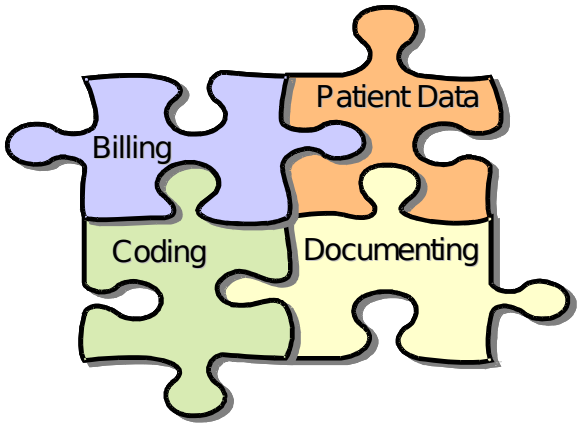
Objectives



- Introduction
- Coding Compliance Editor
- Preparing for CCE
- Daily Operations
- Back End Process
- Realistic Expectations

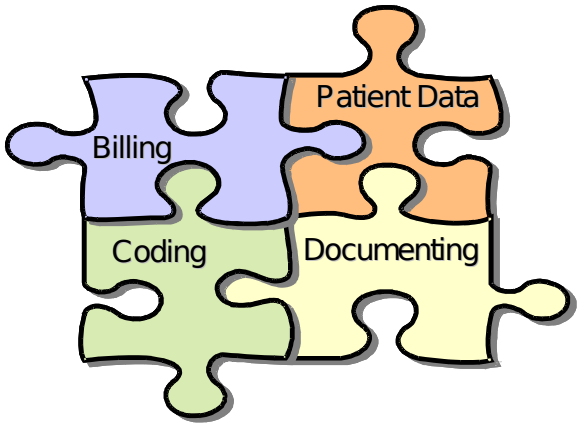
CORE COMPETENCIES

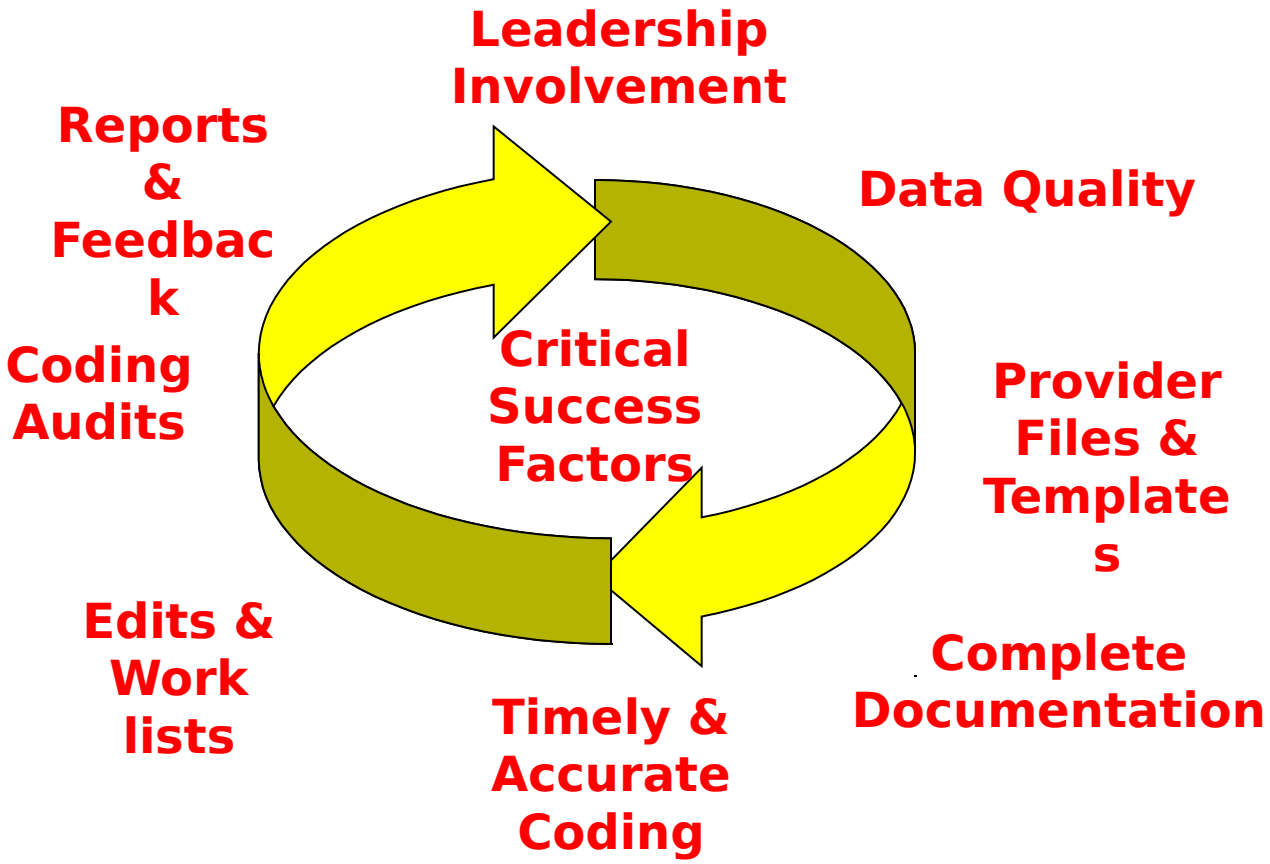
Introduction



- Worker bees standpoint
- Involvement
- Observations
- Results
- Pitfalls

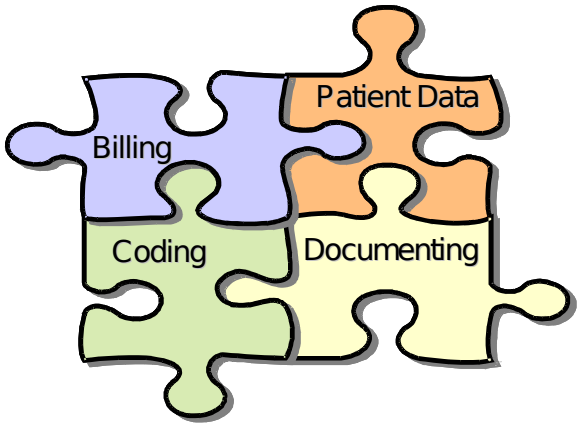
DQ Success of CCE





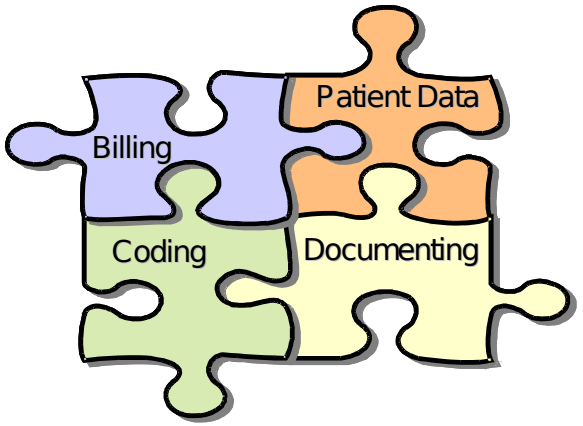
CORE COMPETENCIES

P-GUI/CHCS II



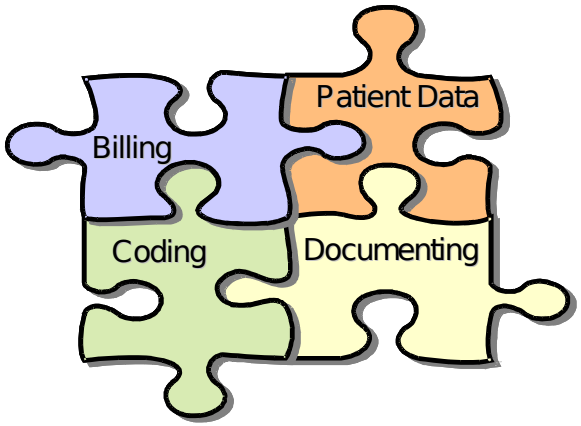
- P-GUI/CHCS II
  - Both overlay CHCS/ ADM
    - P-GUI codes encounter in the background with completion of A/P/D
    - CHCS II calculates codes based on MEDCIN tree

Coding Compliance Editor (CCE)



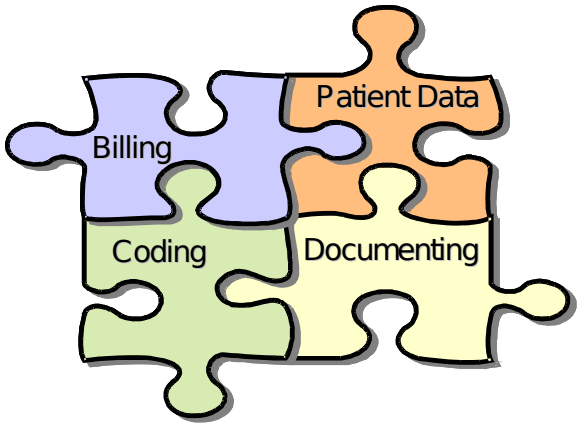
- Automated back-end coding audits/edits
  - Provides correct coding logic
    - Coding support
    - Coding audit support
  - Initial estimates- 80 % rejection
    - Based on current ADM practice

Coding Compliance Editor (CCE) cont'd



- Purpose of CCE
  - Increase accuracy
    - Current Business Plans
    - Lay groundwork for future Biz Plan metrics
  - Minimize billing denials

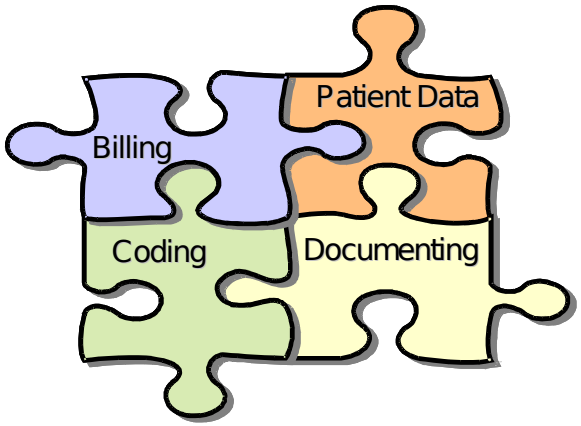
Preparing for CCE



- Leadership oversight & involvement
- Ensure proper file and templates
  - Provider ID, specialty codes are correct
  - Appointment templates & types
- Define roles & responsibilities
  - DQM
  - Systems
  - Coders & Billing staff
  - Clinical Staff
- Train, Train, Train!

CORE COMPETENCIES

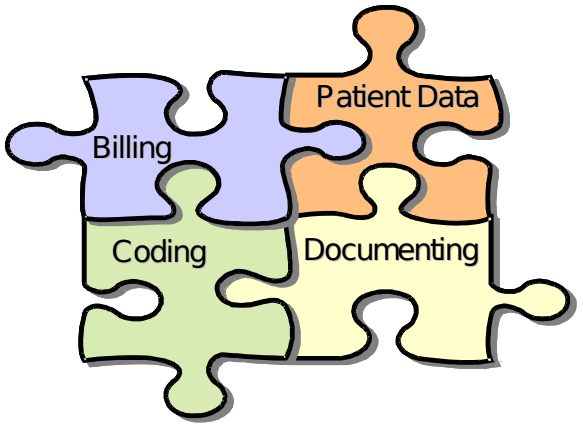
Daily Operations



- Documentation Quality Driven
  - Record availability-P-GUI
  - Sufficient encounter documentation
  - E&M product line specific
  - Non-provider role?

CORE COMPETENCIES

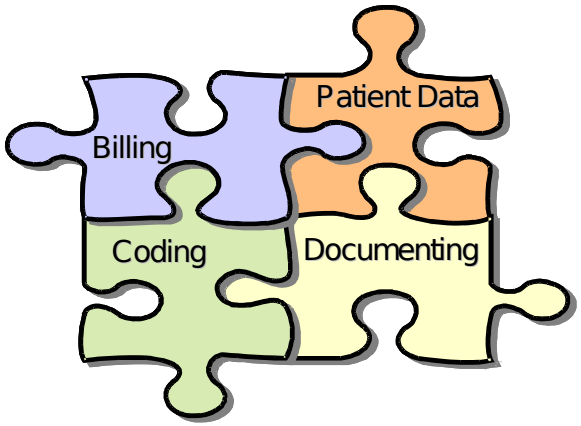
Daily Operations cont'd



- Encounter Documentation
  - Provider education
    - Complete & Accurate coding
      - E&M
      - ICD-9
      - CPT

CORE COMPETENCIES

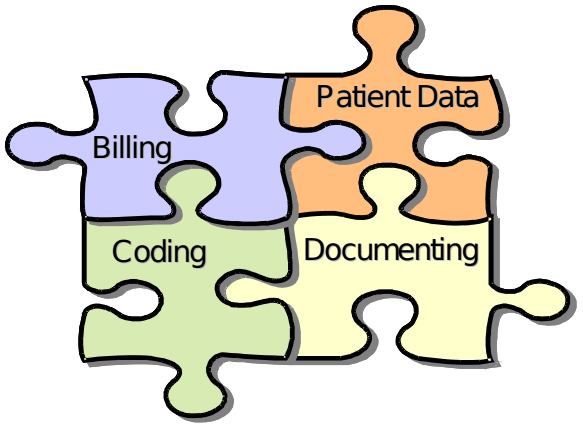
Daily Operations cont.



- **P-GUI/CHCS II or SF600 100%: Make a choice!**
  - Leadership support
  - Clinic leadership oversight
  - Template management

CORE COMPETENCIES

Daily Operations cont.



Example A:

Provider codes 1/2 P-GUI and 1/2 SF600

Results:

1. Poor documentation availability for coding
2. Creates more work for all staff

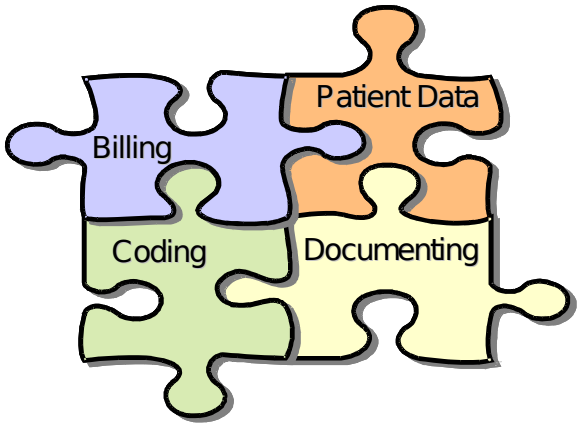
Example B:

Provider codes P-GUI 100%!

Results:

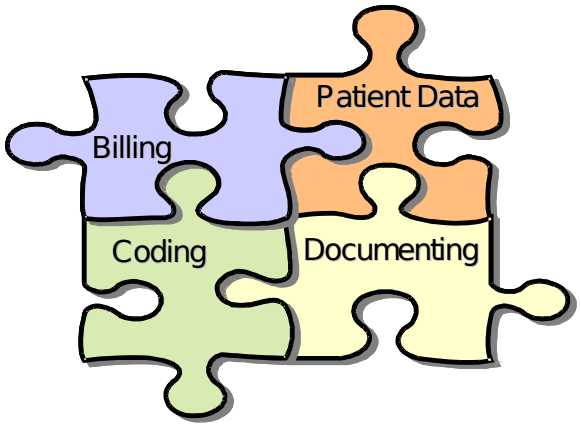
1. Improves record availability
2. Streamlines process throughout facility

Daily Operations cont.



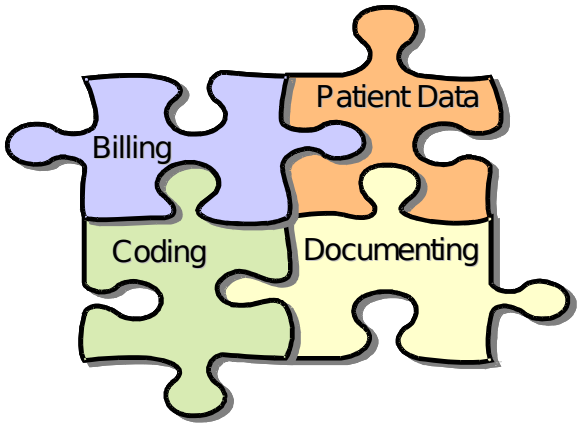
- Recognize importance of Data Quality
  - Planning and tracking diseases
  - Facility efficiency
  - Clinic Staffing/Manning

Back End Process



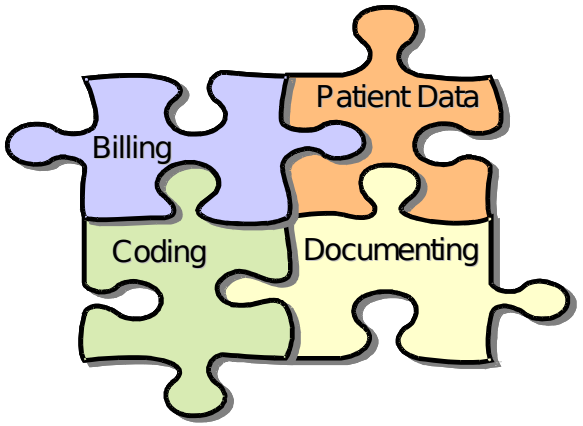
- Data Quality Issues on the back-end
  - Medical Record availability
  - Coder roles
  - Coder Complacency
  - Billing

Challenges



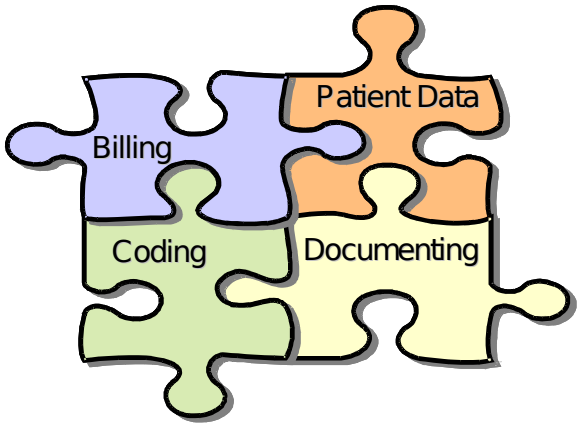
- Multiple organizational involvement
  - MTF
  - Deployment team
  - Coding contract
- Initial workload increase
  - Insufficient coders/auditors
  - Systems oversight
  - Data quality oversight

Challenges cont'd



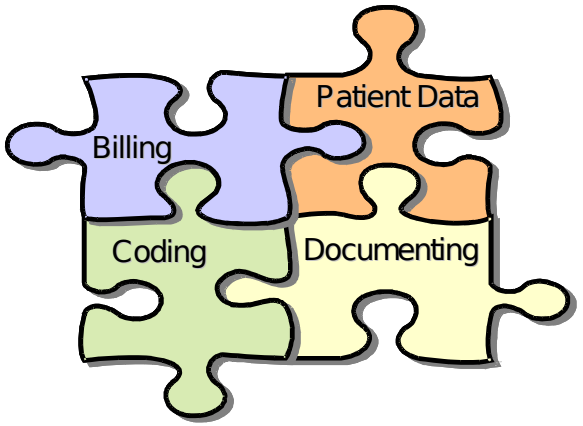
- Focus on priorities and goals
  - Priorities
    - Accurate data
    - Patient care/safety
    - Clinical activity
  - Goals
    - Health Affairs mandates
    - DoD coding accuracy; 97%(05), 100% (06)

Challenges cont'd

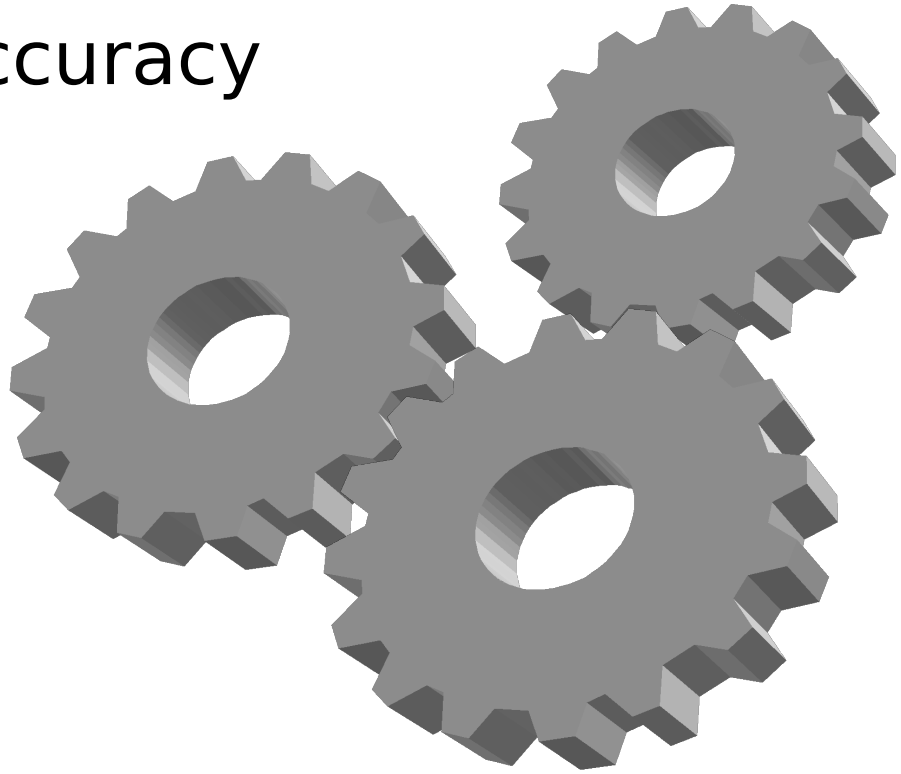


- **Maintain Revenue Cycle**
  - Define process owners
  - Take ownership
  - Don't ignore pieces of cycle
  - Connect organizational differences

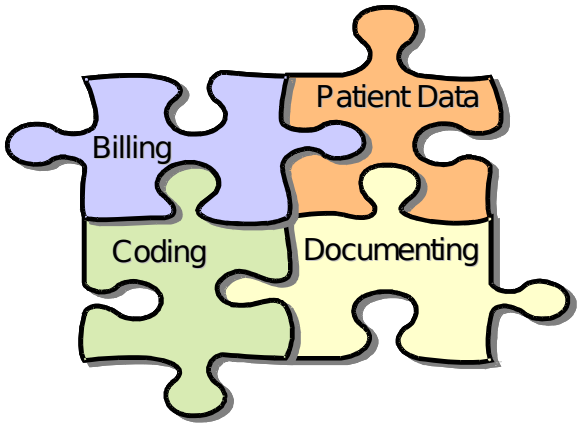
Realistic Expectations



- Data Quality
- Coding Accuracy
- Billing



Realistic Expectations cont'd

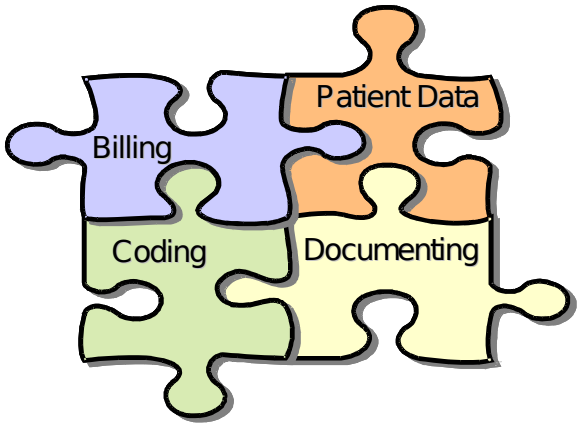


- RVU
- Reimbursement
- Bottom line
  - Budget
  - Manning
  - Biz plan

IF YOU DON'T PUT IN THE TIME, YOU WON'T REALIZE A DIME!

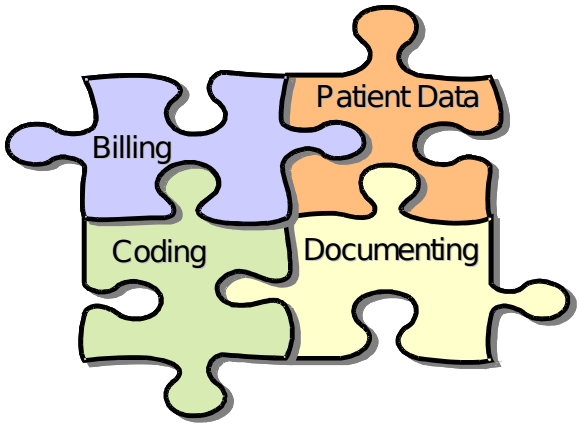
CORE COMPETENCIES

Summary



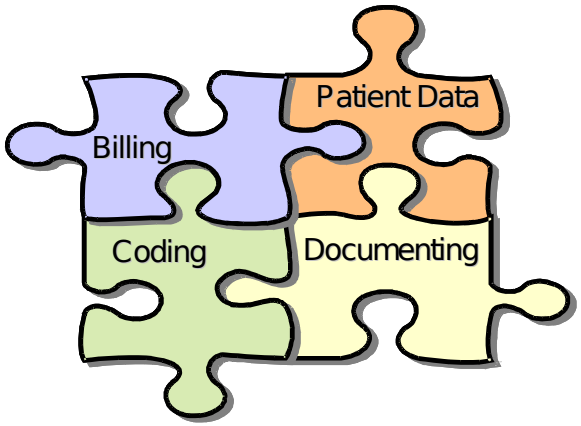
- MTF Prospective
- Understand Coding Compliance Editor (CCE)
- Data Quality Site Preparing for CCE
- Focus
- Results
- Realistic Expectations

CORE COMPETENCIES



Questions?

CORE COMPETENCIES

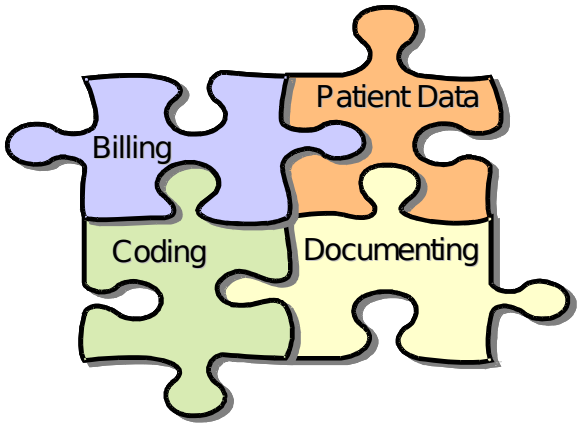


RVU For Everyone

R-2-1100-1205

Mr. Ron James
Chief, Data Analysis Section
PASBA
(210) 295-9113 DSN 421-9113

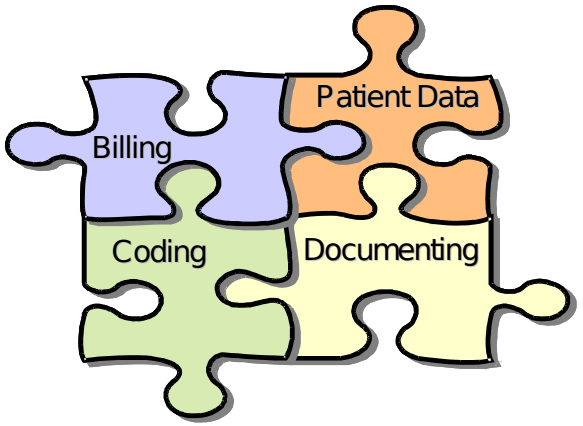
Purpose



- The Purpose of this presentation is to inform the users of the RVU data found in M2 of the different types and meaning and some causes in the in the mis-reporting of RVU.

CORE COMPETENCIES

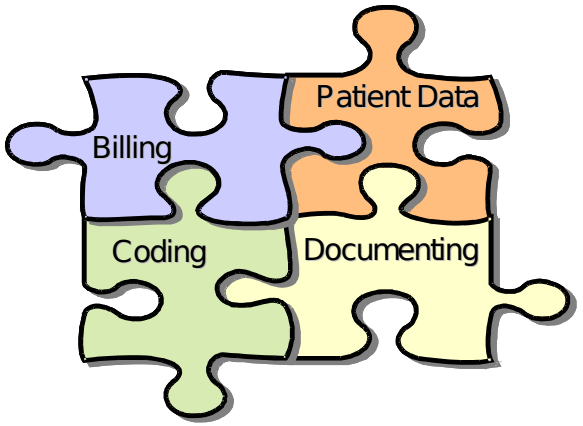
Objectives



- Provide and overview of the construct of RVU
- Provide an overview of the different types of RVU reported in the M2
- Discuss actions that can affect RVU
- Discuss root causes of mis-reporting

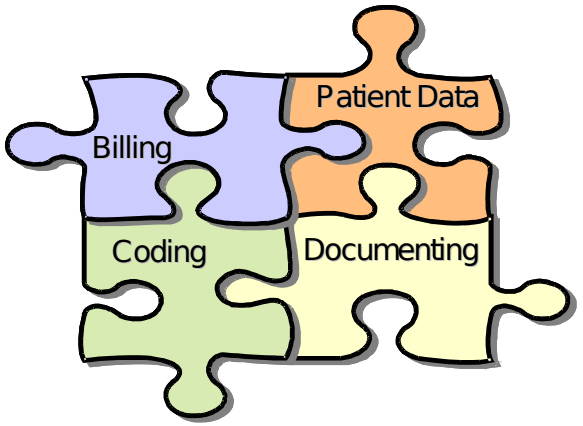
CORE COMPETENCIES

Resource Based Relative Value System (RBRVS) 1/3



- **Fully implemented in Jan 1996.**
- **Basis for Payment under Medicare Prospective Payment System and adopted by most commercial payers to include Tricare.**
- **Original values were the results of a Harvard Study involving 18 specialties.**

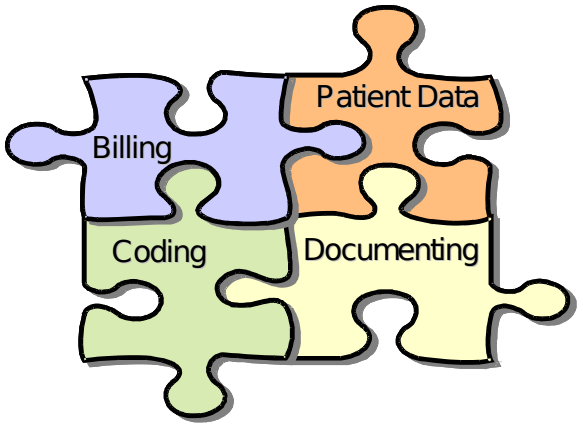
Resource Based Relative Value System (RBRVS) 2/3



- **The Harvard study used the following criteria for defining physician work as:**
  - **Time required to perform service.**
  - **Technical skill and physical effort.**
  - **Mental effort and judgment.**
  - **Psychological stress associated with physician's concern about iatrogenic risk to patient.**

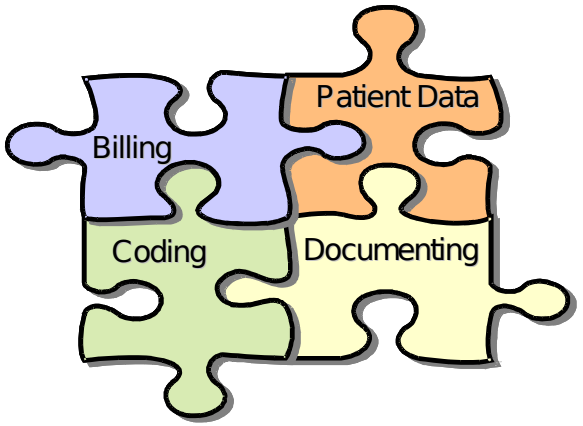
CORE COMPETENCIES

Resource Based Relative Value System (RBRVS) 3/3



- **In reality, the study did not use definition but rather, it used a series of vignettes compared against a base vignette or created composite vignettes to represent an average patient for a particular service.**
- **The key thing to remember is that RBRVS is about payment, not productivity!**

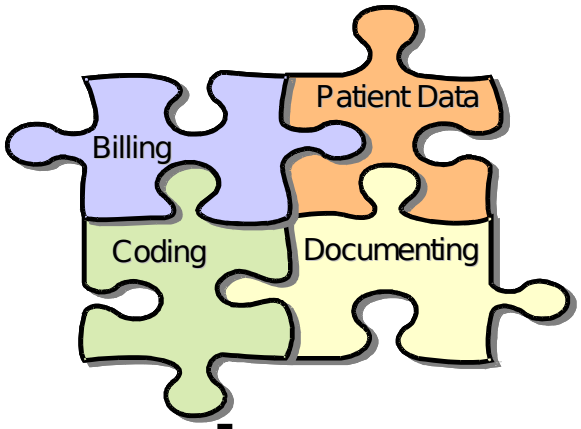
MHS Relative Value Units



- **RVU is used by the MHS as a measure of provider productivity in terms of volume and uses the relative scale as an indicator of intensity of services provided.**
- **The MHS uses alternative sources for RVU when RBRVS sets the RVU at 0.00.**

CORE COMPETENCIES

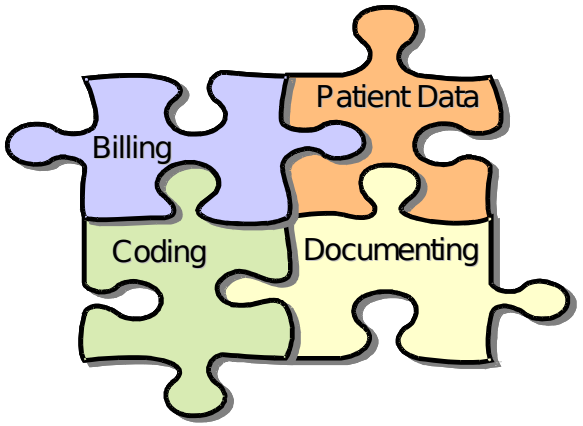
What are the Components of an RVU?



- **The RVU has 3 components:**
  - **Work: Amount of time and effort.**
  - **Practice Expense: equipment/supplies.**
  - **Malpractice Expense: increased risk by specialty.**
  - **NOTE: DoD only uses the Work component for productivity.**

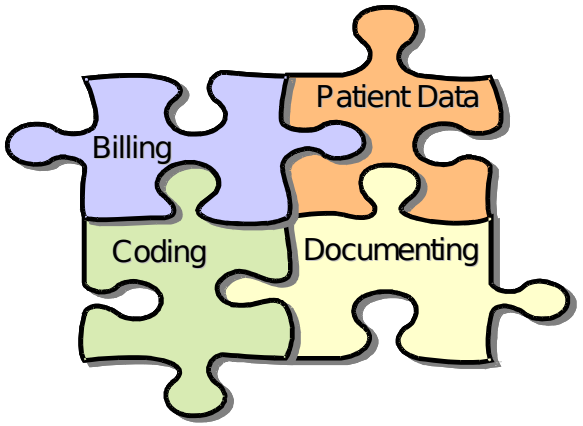
CORE COMPETENCIES

How Does DoD report RVU?



- **The M-2 Reports RVU in 28 ways:**
  - **Simple**
  - **Adjusted**
  - **Provider**
  - **PPS Facility**
  - **PPS Work**
  - **Individual Work**
  - **Organizational Work**
  - **Primary Provider Work**
  - **Secondary #2 Provider Work**
  - **E&M**
  - **Procedures 1-4**
- **Each are either “raw” or “total”.**
- **Total is “raw estimated to completion”!**

RVU Types



- **Simple RVU** is the sum of all CPT-4 code RVU in a given record.
- **Adjusted RVU** discounts secondary procedures by giving 100% for highest weighted RVU and 50% of the RVU weight for each additional procedure.

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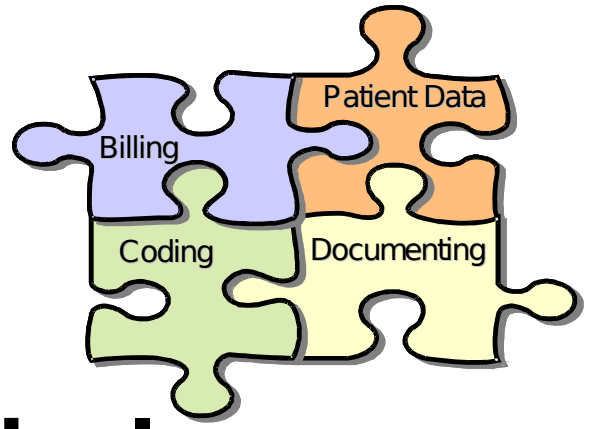
CORE COMPETENCIES

RVU Types



- **Provider RVU** is the Clinical resource intensity calculated by multiplying the adjusted RVU by the sum of the privileged providers

- **PPS Work** is Physician work RVU, multiple physicians, but no discounting

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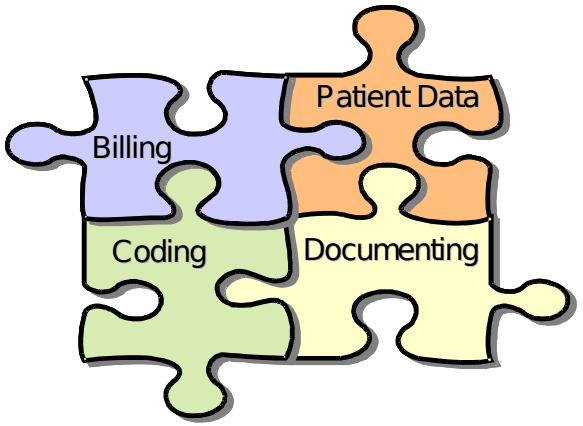
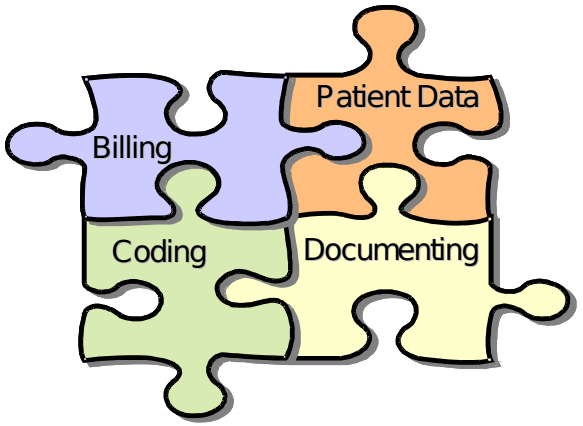
RVU Types



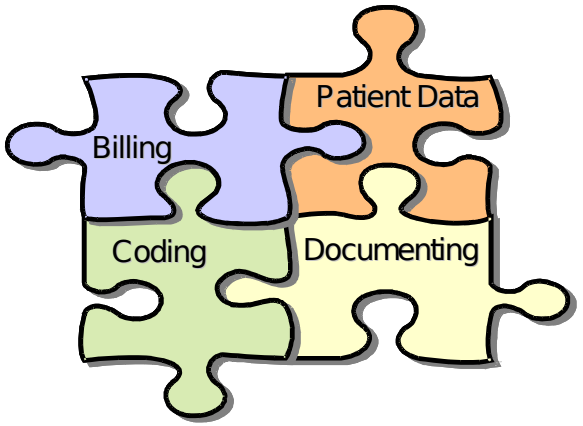
- PPS Facility is Non-facility practice expense RVU, no multiple physicians, no discounting
- Individual Work is Physician work RVU component. (discounting applied, no multiple physicians

RVU Types



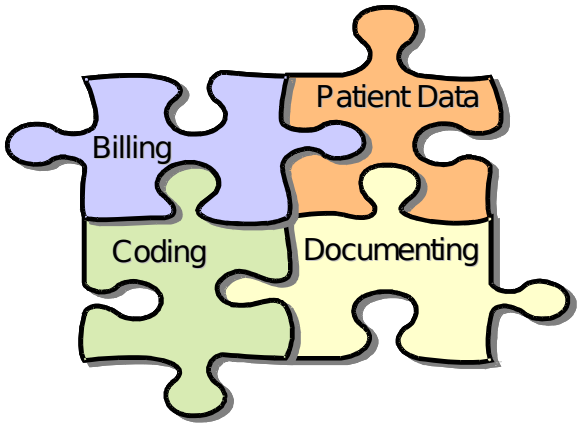
- E&M Procedure is the Relative Value Unit (RVU) associated with the CPT coded in E and M code (Same As Simple)
- Procedure 1-4 are Relative Value Unit (RVU) associated with the CPT coded in each Procedure (1-4) (Same As Simple)

RVU Types



- Organizational Work is derived by multiplying discounted (100% or highest, 50% for remaining) MHS updated Work RVUs by the number of providers based on provider specialty (cleaned) codes

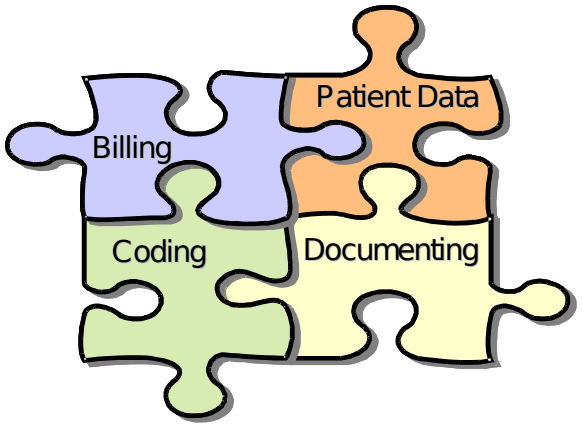
RVU Types



- Primary Provider is Relative Value Unit (RVU) associated with the primary provider (Same As Simple)
- Secondary #2 Provider is Relative Value Unit (RVU) associated with the 2nd secondary provider (Same As Simple)

CORE COMPETENCIES

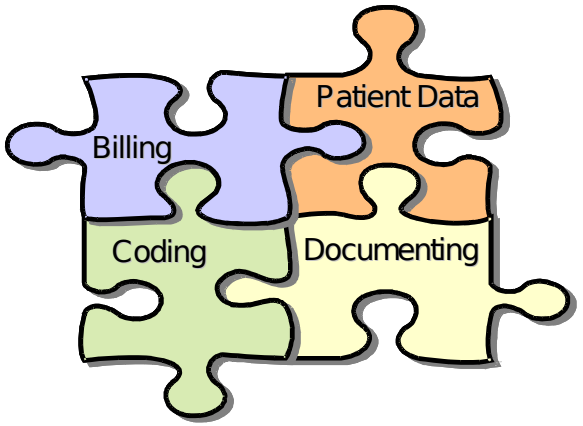
Capturing the RVU for Work Performed 1/2



- **Ensure that the Provider type is correct in CHCS.**
- **Ensure that the actual provider specialty is listed first in the CHCS provider table.**
- **If you have not yet done so, Run the Provider Re-order Utility in CP255**

CORE COMPETENCIES

Capturing the RVU for Work Performed 2/2



- **Fully code all procedures.**
- **Avoid the use of unlisted procedures (e.g. 33999 Unlisted procedure, cardiac surgery).**
- **Do not list zero weighted procedures before weighted procedures).**
  - **<u>Example:</u> 99000 Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory has 0.00 RVU and should be last if even listed at all.**

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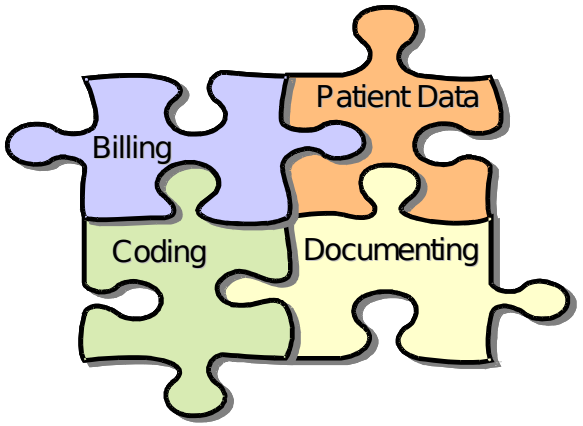
CORE COMPETENCIES

Capturing the RVU for Work Performed 3/3



- **Routine Follow-Up after a sx procedure.**
  - **Most sx procedures are covered under the concept call "Surgical Package."**
    - **Includes Pre-op, procedure and routine follow-up.**
    - **Includes a "Global" period ranging from 10-90 days post-operatively.**
  - **There should <u>not</u> be an E&M other than 99499 (due to ADM limitations) listed for this care.**

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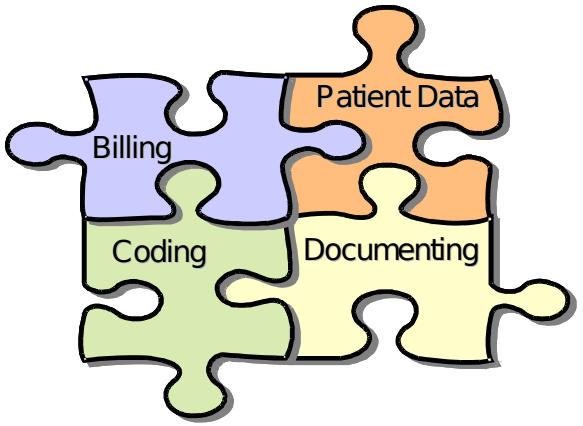
CORE COMPETENCIES

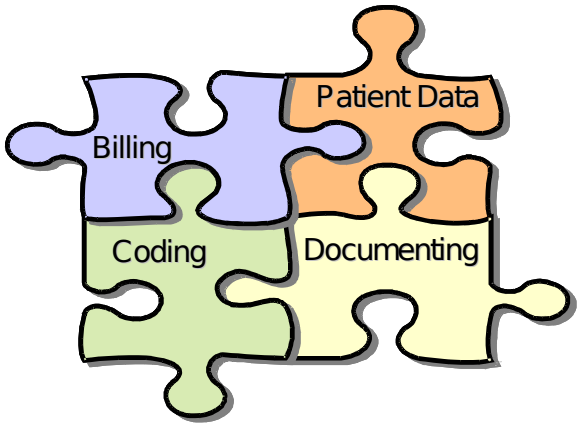
Final Thoughts



- **RVU is directly related to how well the care is documented.**
- **E&M's are major component of most RVUs = must get E&M's coded correct!**
- **Does have a direct impact on Itemized Billing.**
- **RVU are being used to measure productivity and clinical intensity of the care we provide.**

CORE COMPETENCIES

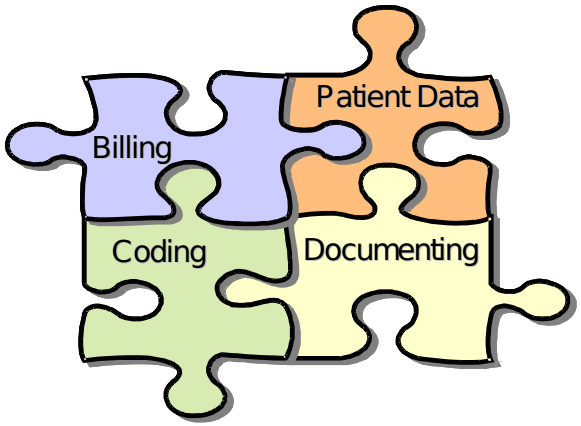
Final Thoughts



Why RVU's Are Low:

- Visits not coded in ADM!
- Visits are under-coded (E&M).
- Not coding (all) procedures.
- High number of no-show appointments.
- Too many unfilled appointments.
- Data for visit not entered correctly in ADM.
- Workload captured elsewhere.
- "System problem" (A diagnosis of exclusion!)

CORE COMPETENCIES

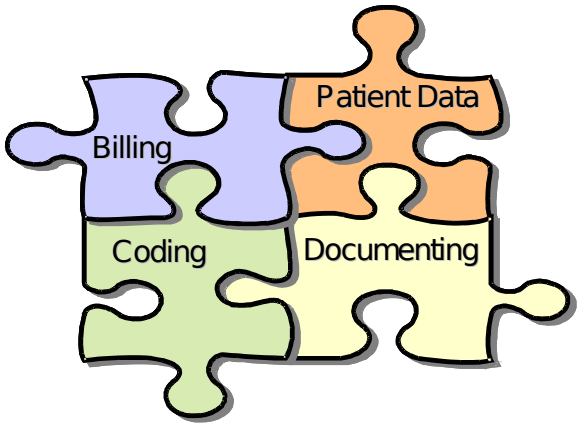


Wrap-Up, Tracks 1/2/3/4

Lt Col Jeanne Yoder
UBO Program Manager
Thursday, 1300, 19 May 2005

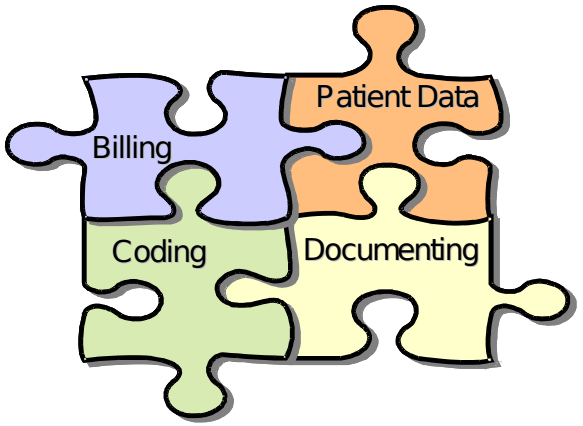
CORE COMPETENCIES

Your Home Work



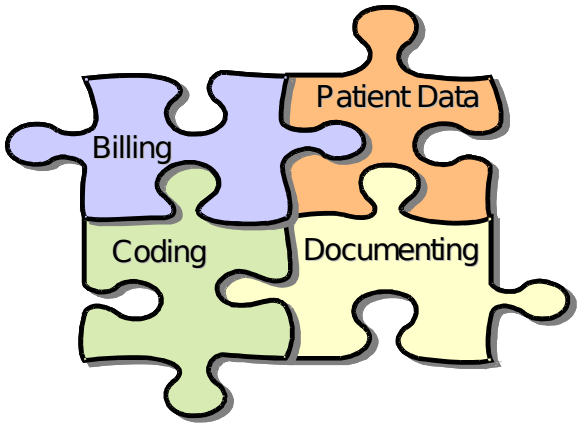
- Review/update your compliance plan
- Training
- Billers – set up meeting with your coders, understand why bills are denied for coding reasons
- Coders – go talk with billers, find out the coding problems, figure out solutions, implement; denied bills are errors you find without needing to audit

The Process – Provider New to Military Treatment Facility (MTF)



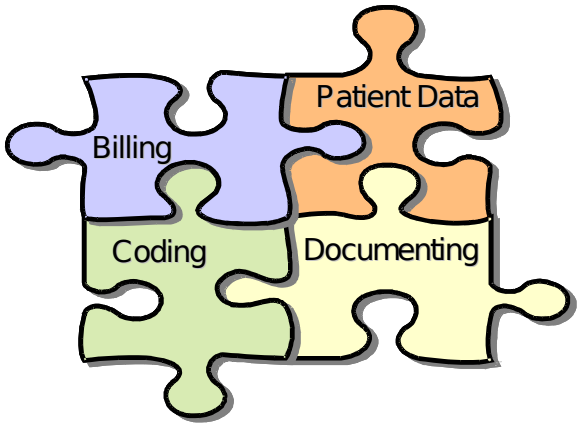
- Provider Specialty Code
- HIPAA Taxonomy
- Abbreviations
- Timeliness of completion of documentation/data entry in ambulatory data module (ADM)
- Institutional versus professional
- Introduce the provider to his coder

The Process – Sit Down One-On-One With Provider



- Document what you do, not just abnormals
- Document conditions/diseases that impact care
- ICD=diagnosis, medical necessity, reason for services
- CPT/HCPCS=what was done, supplies
  - Don’t get credit unless documented
  - Relative value units (RVUs)

The Process – Sit Down One-On-One With Provider

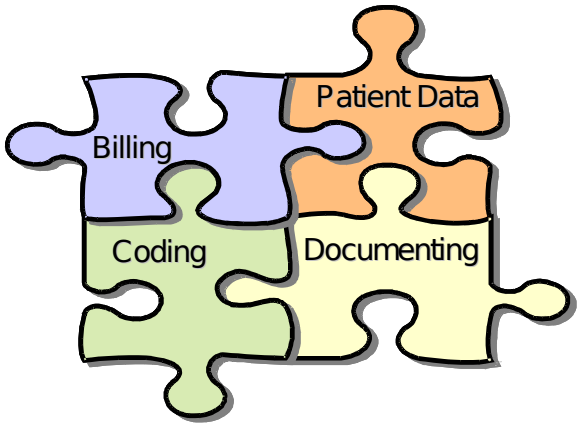


- **Brief provider on how to document**
- Subjective Objective Assessment Plan
- S=HPI, ROS, P/F/S Hx
- O=Vital Signs, General, Body Systems
- A=What found
- P=What you did/and plan to do (e.g., TREAT FX)

- **Military unique issues**
- DoD Extender Codes
- Telephone Consults
- Services “downtown”
- Labs/Rads/EKGs/ vaccinations, in the clinic or not in the clinic

CORE COMPETENCIES

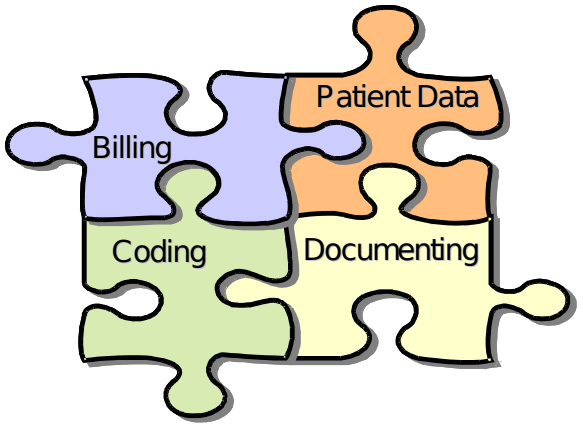
The Process – Sit Down One-On-One With Provider



- What they can dictate (e.g., H&P, operative reports, consults, D/C summary, MEBs)
- What must be in the operative report
- Reviewing and signing dictation, no “SBNR”
- Ours is a decentralized medical record, that the OB, Mental Health and Dental components are usually stored separately

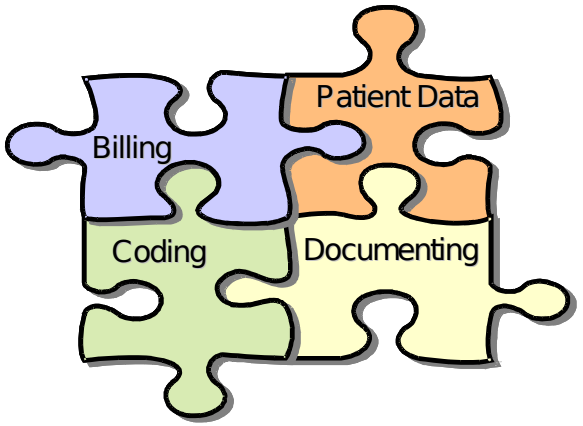
CORE COMPETENCIES

The Process – Sit Down One-On-One With Provider



- Layout of the 4 part medical record
- Documentation on the Summary Sheet counts if Summary Sheet current
- Auto fill function for diagnosis if used (usually only Mental Health and OB), must delete diagnoses not addressed/considered at that encounter
- Auto-negative function in CHCSII, must change if not addressed

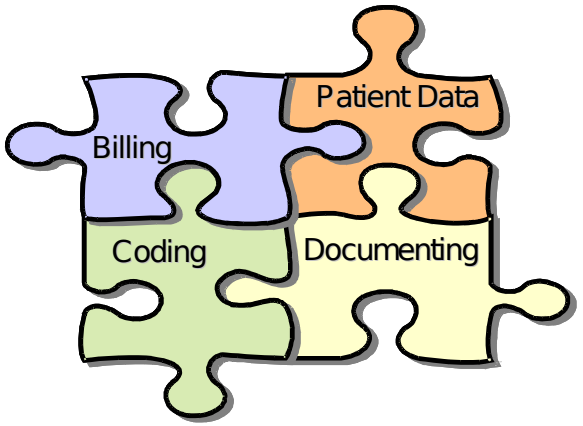
The Process – Sit Down One-On-One With Provider



- Difference between:
  - Consult and referral
  - Office visit and physical
  - New and established patient
  - Conscious sedation, monitored anesthesia care and anesthesia
  - Office visit and optometry/ophthalmology code
  - Telephone consult (workload does count) and telephone call (workload does not count)

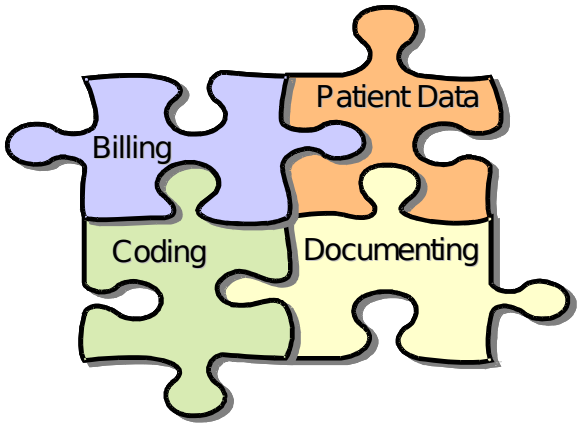
CORE COMPETENCIES

The Process – New Provider One Month Later



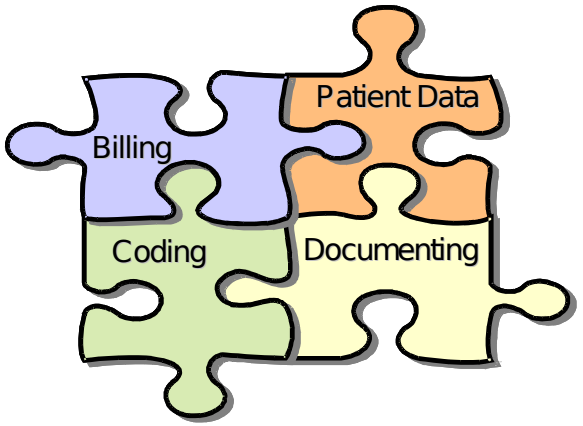
- Feedback and answer questions
  - Review audit findings one-on-one with the provider
  - "If you did this, you should have documented it, you would have had a 99213 instead of a 99212…"
  - Need to know right and left, which finger on which hand; need name of nurse helping with conscious sedation; did you replace the cast or not…

The Process – The Coding Audit



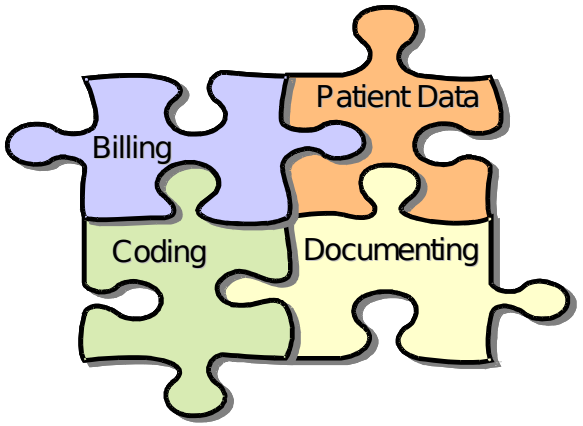
- Always provide individual feedback
  - If there were no findings, let him know, even if it is just a letter “Reviewed 10 of your encounters with no coding errors found.”
- If errors found that could be applicable to multiple specialties, brief at Professional Staff Meeting

The Process – Brief at Professional Staff



- External Cause Of Injury Coding
- DoD Extenders to include Deployment Related
- Injury Logs, or at least the Injury/Accident flag
- Medical Affirmative Claims records must be back in file at end of duty day

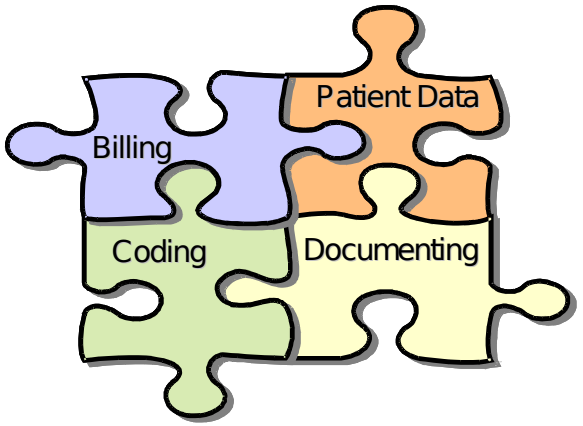
The Process – Patient is New To MTF



- Collect patient data to include DD Form 2569
  - Send form to UBO office for entry into CHCS
- Patient's address and telephone number (check and update every time the patient makes an appointment)
  - Update on DMDC web site

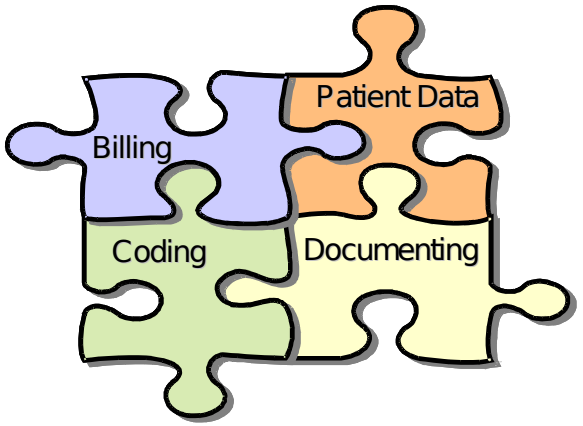
CORE COMPETENCIES

UBU Home Work



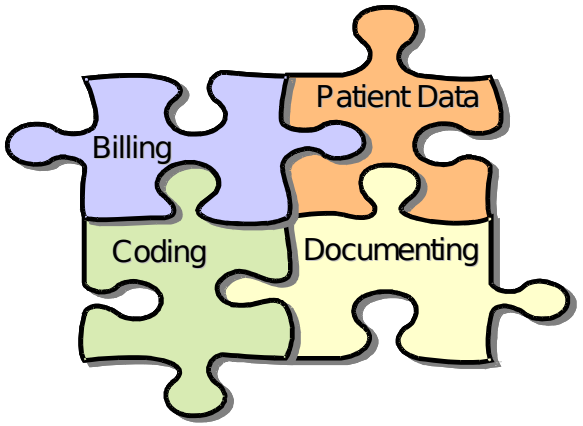
- Teach providers how to document
- Teach admission clerks and appointment clerks
  - PATCATs and how to change them for each encounter
  - Injury/Accident flag
- Audits – get the results of external audits from your Service POCs
- Audits – are not complete until there is provider feedback (both positive and how to improve)
- Get 5 minutes every month at Professional Staff for audit findings, new codes, documentation…
- Coding/documentation in-services

The Process – What Will Generate A Third Party Bill



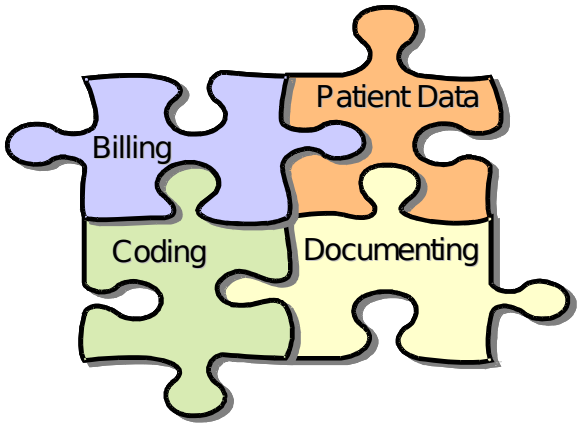
- NOTHING unless DD 2569 data is in CHCS
- Privileged provider visits, not technician visits
- CHCS Provider Specialty Code 000-901, except 900
- HIPAA taxonomy

The Process – What Will Generate A Medical Affirmative Claim (MAC)



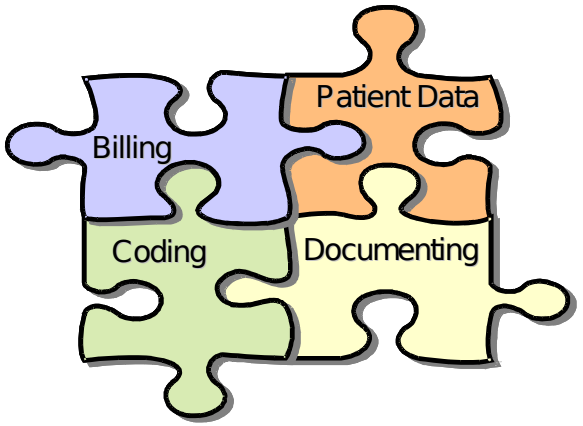
- Patient care due to injury caused by another party who has insurance, or by the patient who has insurance (e.g., single car accident)
- Injury Log
- Strong MAC program
- Claim data sent to Legal upon completion of care for that injury
- Understand use of ICD E-codes and follow-up codes

UBO Overview



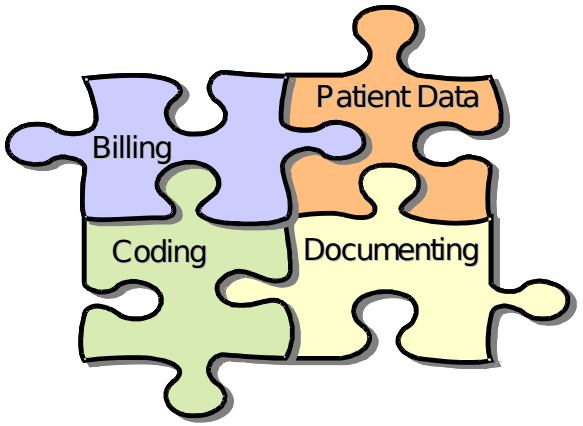
- 3 Major Cost Recovery Programs
  - Third Party Collection (TPC)
  - Medical Services Accounts (MSA)
  - Medical Affirmative Claims (MAC)
- Other Cost Recovery Program
  - Dept of Veterans Affairs Joint Venture

Electronic Billing



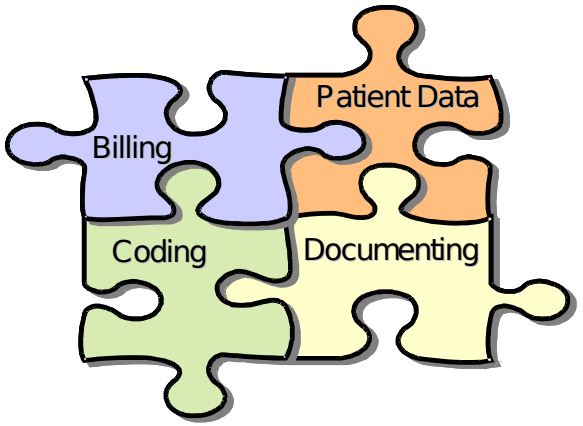
- Work with your credentials staff to ensure provider data are correct
- Costs less to process claim electronically
- Know that day if something is missing on the electronic claim
- Remittances faster
- No deductions because of using paper bills

Provider Specialty Code



- Impacts TPC
  - Only generate bills for codes 000-901 (except 900)
  - If no provider specialty code (field left blank) – does not feed to Third Party Outpatient Collection System (TPOCS)
- Enter during provider inprocessing to the MTF and when status changes (e.g., resident to fully privileged provider)
- Work TPOCS edit list EVERY day

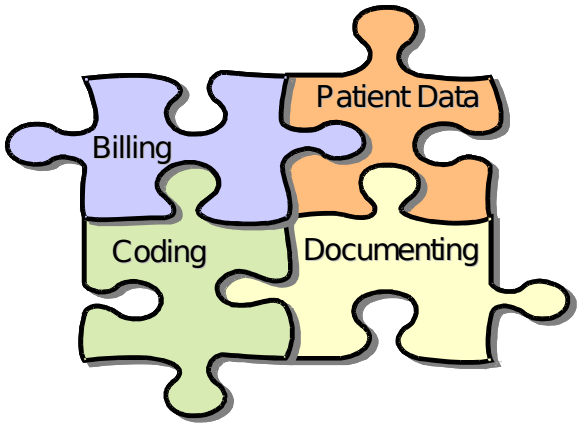
Correct PATCAT Classification



- Impacts Medical Services Accounts (MSA)
- Coast Guard = C, this care is billed back to the Coast Guard IF the PATCAT is correct
- Uniformed Services is more than the Army, Navy, Air Force and Marines
  - NOAA, PHS, Coast Guard
- Patients with multiple benefits
  - VA and DoD; Retired and Occupational Screening; Family Member and Reservist; DoD School and Retire/Family Member…

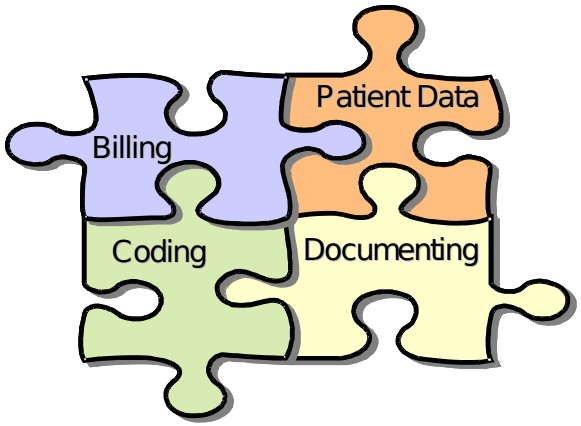
CORE COMPETENCIES

GAO Audit



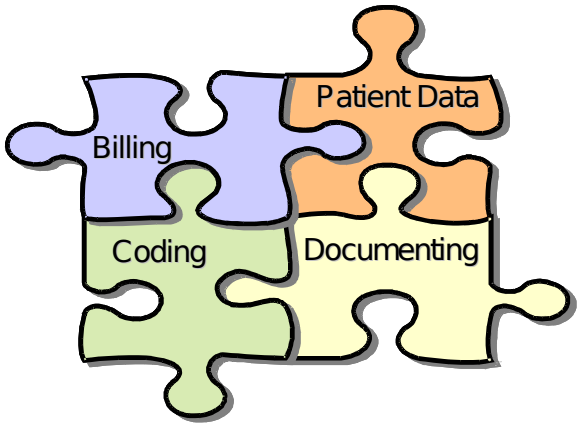
- 20 Feb 2004, MTF: Improvements Needed to Increase DoD Third-Party Collections, page 3, 1st and 2nd sentences
- "The single biggest obstacle to increasing collections, however, is inadequate identification of patients with third-party insurance. DoD does not have effective systems or processes for obtaining and updating insurance information for patients that have other health insurance coverage."

DD Form 2569



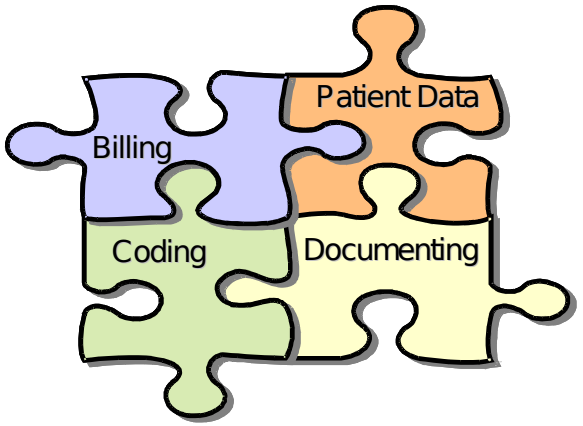
- DD Form 2569 - Third Party Collection Program – Record of Other Health Insurance
  - Also used for MSA
  - Current within past 12 months
  - The 2569 must be signed during each inpatient stay and APV visit
  - In outpatient medical record (which is why YOU need to start medical records at YOUR MTF for non-enrollees)
  - In CHCS (how system knows to feed data to TPOCS)

Injury Log



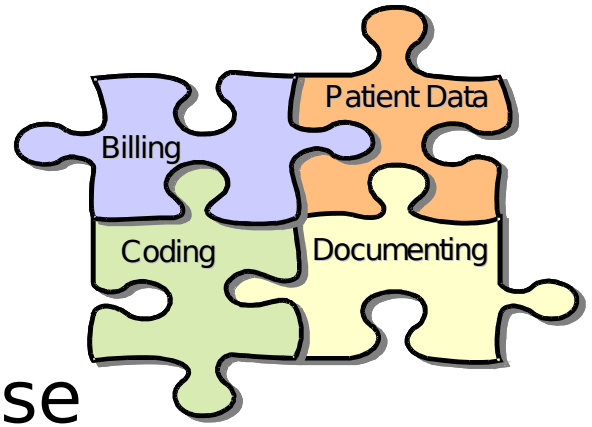
- Impacts Medical Affirmative Claims (MAC)
- Clinics (particularly Emergency Department and primary care clinics) need to identify patient's initial treatment for all injuries
- Clinic staff need to understand importance of using injury log
- Systems Change Request funded to have "Injury/Accident" prompt when making appointment and at patient check-in

Completed MAC



- If MAC patient is not seen for 30 days
  - Review CHCS for walk-in visits, t-cons, etc
  - Check last documented soaP (plan) for the injury
  - Ask provider if care is complete
- Generate bill and forward to legal

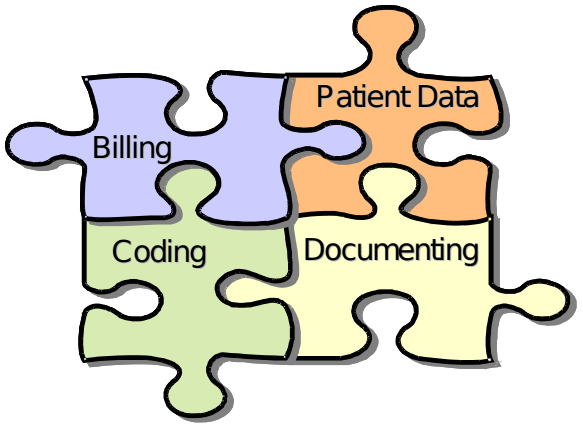
Cosmetic Surgery



- NEW billing method with release of next rates package – contact your Service POC if you do cosmetic surgery billing and did not attend the class
- Impacts Medical Services Accounts (MSA)
- Be sure your clinicians know to send patients scheduled for cosmetic surgery to the MSA office
- Clinician determines if it is cosmetic surgery or reconstructive surgery

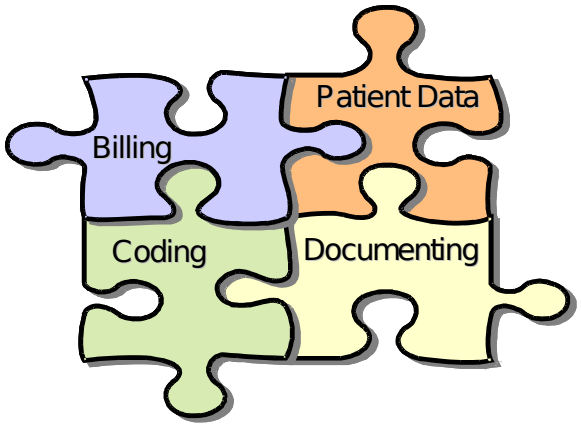
CORE COMPETENCIES

Accounts Receivable



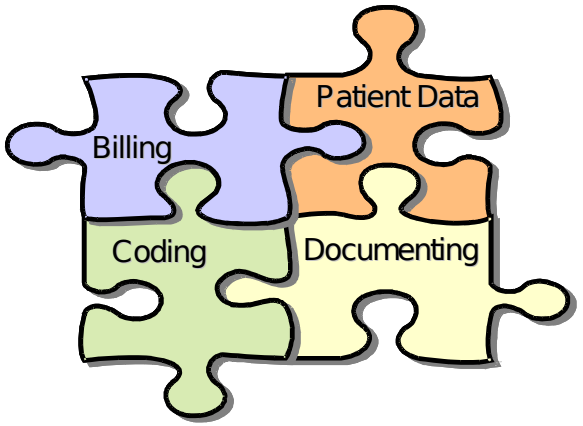
- Impacts TPC, MSA
- Follow-up, follow-up, follow-up
- Congressional TPC Reporting
  - Inpatient: Claims/disposition, 10%
  - Inpatient: Collected to billed, 45%
  - Inpatient: Closed to billed, 60%
  - Outpatient: Collected to billed, 50%
  - Outpatient: Closed to billed, 45%

TPOCS Edit List



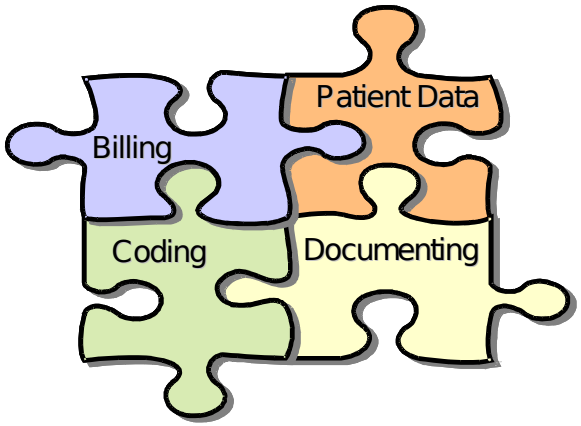
- Impacts outpatient TPC
- Work it every day
  - Once it is cleaned up, it is easy to keep it cleaned up

UBO Home Work



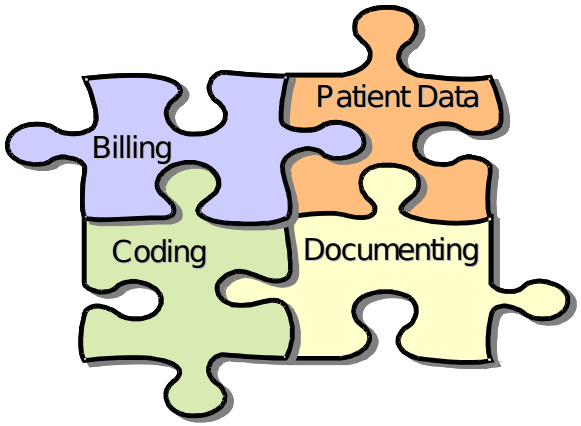
- UBO Priority List
- Electronic Billing
- Provider Specialty Code
- PATCAT
- DD Form 2569
- Injury Log
- Forward completed MAC packages to legal
- Accounts Receivable
- TPOCS edit list
- Cosmetic Surgery

Coding



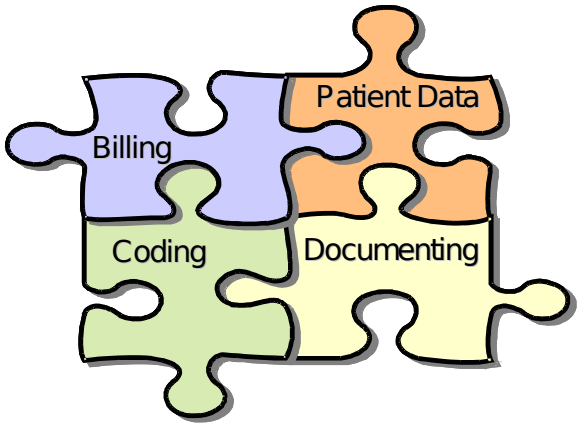
- Impacts TPC, MSA, MAC
- Review the new MHS Coding Guidance
- http://www.tricare.osd.mil/org/pae/ubu/default.htm
- Document what is done
- Code what is documented

Objective



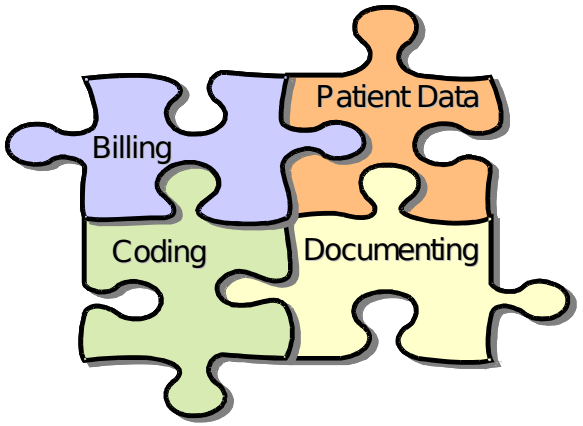
- Know how to increase MTF revenue
  - Provider Specialty codes in CHCS
  - Correct PATCAT codes
  - Cosmetic Surgery
  - DD Form 2569
  - Injury Log
  - Forward completed MAC packages to legal
  - Coding
  - TPOCS edit list
  - Accounts receivable management

Summary



- Review/update your compliance plan
- Training
- Billers – set up meeting with your coders, understand why bills are denied for coding reasons
- Coders – go talk with billers, find out the coding problems, figure out solutions, implement; denied bills are errors you find without needing to audit

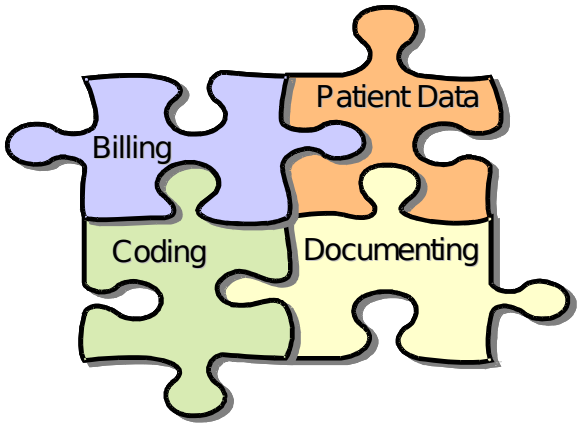
BOTTOM LINE:



- Have a safe trip home
- Share what you have learned

CORE COMPETENCIES

Questions



- Fill out your class comment forms
- Comments improve future classes
- Turn in comment form for a CD with all the class briefings – excellent to use as teaching component of your compliance plan
- At the same time, pick up your course participation form
- Keep your handouts with comments for Continuing Education documentation
- Next class: Service Breakouts